CASES

IN

MIDWIFERY,

BY THE LATE

JOHN GREEN CROSSE, M.D., F.R.S.

ARRANGED

(With an INTRODUCTION and REMARKS),

BY

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TO

J. G. JOHNSON, ESQ., F. R. C. S.

LATE SURGEON TO THE NORFOLK AND NORWICH HOSPITAL.

MY DEAR SIR,

Your constant friendship and co-operation with the eminent Surgeon whose cases I have endeavoured, in this little volume, to render useful to the Profession, would alone offer a sufficient inducement to dedicate it to you; but when I remember also the many instances of personal attention I have received from you both, conjointly and individually, it becomes a pleasing duty thus to acknowledge the obligation. As I deeply lament the loss of the one valued friend, so do I appreciate the possession of the other, and hope sincerely for the long continuance of your estimable and useful life.

Accept,

MY DEAR SIR,

The best wishes of your's, faithfully,

E. COPEMAN.

PREFACE.

THE idea of presenting to the public the work now published was first suggested to me by Mr. CROSSE; who, although he felt he could not, from incessant engagements, undertake the arrangement of it himself, expressed a belief that a careful perusal of the cases would be instructive to junior members of our profession, provided they were judiciously arranged and commented upon. Mr. Crosse did me the honour to entrust the manuscripts to my care, with an encouragement to carry out what he himself had not time or opportunity to perform; and a portion of the work was sent to the press previously to the lamented death of him whose experience, it was hoped, would be a benefit to the members of the profession practising Midwifery. The advantage to have been derived from his supervision, was but one of the many losses sustained by the death of Mr. Crosse; every member of the profession in this city and county feels that he has lost a kind and able adviser, and would, I

doubt not, acknowledge the existence of a void in professional experience in the district, that cannot easily be supplied. Of methodical men, he was one of the most methodical; punctuality he always considered a duty, as he found it invariably necessary to the due fulfilment of the requirements of an extensive practice; those who have had an opportunity of witnessing the large accumulation of professional and other cases, notes, and memoranda, which he has left behind him, can amply testify to the vast amount of industry he exercised; and if ever a man possessed the desire and the qualifications for imparting professional knowledge either to those who as practitioners consulted him, or who as pupils expected to be taught by him, Mr. Crosse was pre-eminent in these most useful and beneficial characteristics. The importance he attached to taking notes of cases, was always duly impressed upon his pupils; and so great was the facility he obtained from constant practice, that I have rarely found it necessary to make either alterations, additions, or omissions in the cases which form the principal portion of the present work. I might have altered the construction of some of the sentences, but have preferred leaving them in the form in which they were originally penned, as a guide for the ready and sufficiently accurate method of reporting. As regards the benefits resulting from taking cases, I may here quote his own observations prefixed to the MS. volumes from which I have collected the contents of this book:—

"Upon the utility to be derived from my keeping a registry of the kind I now undertake, I shall make an observation or two. In regard to their extent, registries of private practice in Midwifery must always fall far short of those kept at large public institutions; but at the same time those offer some recommendations to which these cannot lay claim; 1st, because kept by the practitioner himself; 2nd, because relating to a different class of women, viz., those in the middle and higher ranks, and not in the very lowest; 3rd, because abortions may be introduced, which are never noticed, because never occurring, in public institutions; 4th, because the practice may vary somewhat according to circumstances; for instance, in public institutions, instruments may be used late, owing to the negligence, or absence, or indolence of the accoucheur; but never more early than is deemed necessary for the relief and safety of the patient, because her solicitations will not be attended to—whereas in private practice the impatience of the patient, or the interference of the friends, may so tease the practitioner as to bias his judgment and urge him to have recourse to instruments sooner than he deems to be absolutely necessary.

"That a registry of private Midwifery practice may afford any rule for estimating the proportion of preternatural cases in the middle and higher classes of society, cases of consultation must be excluded or kept separately, those only being included in the general registry

who employ him in the common course of his profession, such as are able and willing to give him such a fee as he demands. If, as a practitioner gets better established, he takes no patients without a double fee, he may then have an opportunity of observing whether the proportion of troublesome or preternatural cases continues the same after his practice has become limited to a still higher class in society than at the commencement of his practice.

"In the following registry, I shall not attempt to notice all the slight varieties of the head presentations; because the labour is sometimes so far advanced before I am present, that this cannot be ascertained; nor, if I were present, should I always feel it necessary, where the patient has previously had good times, and the present labour seems to advance well, to be at the trouble to ascertain it very precisely. Amongst the advantages of private registers may be placed the opportunity of observing repeated labours in the same individual; whence an estimate may be formed of the chance of a woman who breeds at all, having a certain number of children in a given number of years.

"The history of diseases during utero-gestation, as connected with labour, can only be met with in the registry of private practice; and the same may be observed of those diseases consequent to labour which do not terminate quickly.

"In a practice which is shared by the most ignorant old women in the universe, we must expect to meet with

prejudice, ignorance, and error. The Accoucheur has to manage his patient, to manage her labour, to manage the prejudices of the public: but I do not mean at present to make any remarks upon the first and last of these three heads, the second only being the philosophical branch of this part of our profession."

It is impossible for me to feel otherwise than diffident respecting the manner in which I have performed the task assigned to me by Mr. Crosse some time ago, and which I have now accomplished; I have felt strongly that the memory of so great a man ought to be perpetuated by a much more talented elucidation of his professional labours than I have been able to offer; and were it not that I possessed a conviction of the intrinsic value of many of the following cases, I should have shrunk from the responsibility which his kindness and confidence have imposed upon me.

In offering the present volume to the public, I cannot avoid impressing upon those who may be inclined to peruse it, that the principal object in publishing it has been to invite a careful perusal of the cases extracted from the late Mr. Crosse's note books; the remarks I have ventured to append, have been introduced for the sake of elucidating some few points connected with Midwifery practice, and of reminding those who are beginning to be engaged in it, of the duties which, as conscientious and honourable practitioners, they ought

to remember and to perform. I cannot but suppose that imperfections in no small number will be found by those who have had extensive experience in Midwifery; but if they recognise in the remarks I have made, anything that may be useful to such as have had fewer opportunities of gaining knowledge than themselves, I trust they will be lenient in their judgment, and give me the credit of having contributed my *mite* to the advancement of this very interesting and responsible branch of the medical profession.

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have arrived at considerable proficiency. It is argued that more decency is observed by employing midwives; that it is more delicate for one woman to assist another in time of labour; and that much distress of mind and shock to modesty are avoided by having females to officiate instead of males. There is certainly an appearance of correctness in such arguments, and they would weigh very strongly were the assistance required of midwives such only as is wanted in the majority of common natural labours. But Midwifery can no longer be regarded as so simple and straightforward a matter; it is a subject possessed of intense interest and paramount importance; and when it is considered, that in order to instruct even a female sufficiently to enable her to undertake anything more than the most ordinary duties, a description of study is required which must necessarily be repulsive, indelicate, and peculiarly uninteresting to the sex, I think it will be allowed that the teachiug women the mysteries of the art, the anatomy, the physiology, the pathology of the parts concerned in parturition, must be more productive of injury to the moral feelings, than the attendance of a properly-conducted male practitioner at the time of child-birth.

The study of Midwifery is exceedingly extensive; it embraces a great variety of subjects; and a correct knowledge of its principles is of vast importance to the community at large. It includes Anatomy and Physiology; morbid Anatomy and Pathology; the nature and effects of medicines of various kinds; the performance of several important operations; and, what is of more consequence still, the knowledge of the circumstances which require, or which contraindicate, their performance. It is of great interest and value also in a medico-legal point of view; with reference, namely, to infanticide, concealed delivery,

the period of utero-gestation, rape, &c.; and the *practice* of Midwifery is the most responsible and delicate of all branches of medicine, seeing that it has to deal with the protection of life during the most interesting of all processes, and in the most interesting of all circumstances. Could it be distinctly known beforehand, whether any particular case would be easy and natural, or difficult and complicated, it would be well perhaps to encourage the attendance of women upon the former, and to require the services of a surgeon for the latter. Such foreknowledge is not, however, attainable; and looking to the great extent of information required for Accoucheurs to be competent to the management of *all* cases that may present themselves, and seeing that they cannot be qualified for the greater without being fully conversant with the less, it does appear of the highest importance that a good education be ensured to all who are destined to practice Midwifery; that when so qualified, they be protected by law against the unqualified; and that if women be employed at all, such alone should be engaged as, from their knowledge of the most ordinary and common cases, are competent to distinguish any irregularity in the natural process, and can be relied upon to summon surgical assistance whenever such irregularity, be it great or small, presents itself. The object of my argument is, to prove that the practice of Midwifery is more safe and efficient, and not more repulsive in a moral sense, in the hands of properly qualified gentlemen, than in those of necessarily less competent midwives; taking into consideration the diversified nature and great amount of knowledge required by accoucheurs.

It is true that, even in the hands of male practitioners, some miserable mal-practices have occurred, reflecting everlasting disgrace upon those by whom the acts have

been perpetrated; it is difficult to attribute such delinquences to other causes than ignorance in the first instance, and fear of exposure afterwards; and some of the blame surely rests with those in authority, for not having compelled all who pretend to practice Midwifery, to become properly qualified by an ample education, tested by stringent examination. It is much to be desired, that in the event of any measure of medical reform being adopted by the legislature, it may be made incumbent upon those who regulate the education of students in the medical profession, to attach more importance to the subject of Midwifery, both by teaching and examination, than has hitherto prevailed.

It may perhaps appear superfluous to add another to the number of works already published, works of great merit and utility, on the subject of Midwifery; but that which I now bring before the notice of the profession is of a different character to most of them; and can, I would fain believe, scarcely fail to benefit the attentive reader. It consists principally of cases occurring in the consultation practice of Mr. Crosse, regularly reported by himself; and it must be a matter of regret, that that gentlemen has not had the time and opportunity to arrange them for publication. If interest in the subject and desire for knowledge be sufficient qualifications for the task, I feel I may venture to consider myself competent to perform it; but these can in no wise compensate for the loss of such experience and practical talent as would have been insured, had Mr. Crosse himself engaged in the undertaking. The manuscripts were placed in my hands, accompanied by the following note; and since Mr. Crosse has honoured me with the charge of them, I trust the Profession will sympathize with, and appreciate, my desire to fulfil the duty assigned to me, and be lenient

in their judgment as to the ability displayed in its performance.

Norwich, Oct. 10th, 1845.

My dear Sir,

You are well acquainted with my habit of noting, during many years of an active professional life, all cases connected with the subject of Midwifery. With increasing and diversified occupations pressing upon me, there is no prospect of my turning these accumulated documents to any use; I am unable to determine whether they can be turned to any useful account by other hands; but, confiding in your judgment, industry, and zeal, I commit these documents to you, to be dealt with in whatever manner you may consider best; remaining always,

My dear Sir,

Your's, most sincerely,

J. G. CROSSE.

To Edward Copeman, Esq.,
Surgeon,
Coltishall, Norfolk.

Independently of the consultation cases, and a chapter on Abortion, which form the body of the work, I have arranged a table of 1377 labours occurring in Mr. Crosse's private practice, in which is shewn,—

1. The average age at which labour has occurred.
2. The number of children, male and female.
3. The number of Twin cases.
4. The average duration of labour.
5. The number of cases in each pregnancy.
6. Number of children, male and female, still-born.
7. Number of cases in which instruments were used; specifying how many times they were used in first, second, third, fourth, &c., labours.
8. The presentations.
9. The number of deaths, and the names of the diseases which occasioned them.

These are all interesting particulars, and they might be usefully compared with similar statements from public institutions and other sources, to shew the relation existing between public and private Midwifery practice. But it is difficult to institute these comparisons in each particular, from there being so many different methods of making records of cases; nevertheless, in one important item, namely, the mortality of women occasioned by child-birth, it is both interesting and easy to compare.

In the following table of a portion of Mr. Crosse's private practice, it appears that instruments were used in 84 cases out of 1377, or 1 in $16\frac{2}{5}$.

That in 1394 presentations, 1320 were natural; or one unnatural to about 19 natural.

That of the unnatural presentations, those of the breech were the most frequent, 1 in $49\frac{11}{14}$; next, face to the pubes, 1 in $53\frac{3}{5}$. Footling cases were in the proportion of 1 in $174\frac{1}{4}$. Presentation of the face, 1 in 279.

The number of still-born children was 71, or one in about $19\frac{5}{8}$; and the mortality amongst the mothers was one in about $98\frac{1}{3}$, inclusive of two deaths from consumption, which would have taken place independently of child-birth; omitting these, the mortality was 1 in $114\frac{3}{4}$.

The twin cases were in the proportion of 1 to 80, or 1 in 81.

TABLES.

No. of Labours.	Average Age.	No. of Children.	Twins.	Average duration of Labour.
1377	30	737 M. 657 F.	17	8 hours.

No. of Cases in each Pregnancy.

1.	2.	3.	4.	5.	6.	7.	8.	9.
356	249	189	155	122	83	68	48	35

10.	11.	12.	13.	14.	15.	16.	17.
27	19	13	6	2	2	1	2

No. of Children still-born.
42 M. 29 F. Total 71.

No. of cases in which Instruments were used, 84 ; viz.
Forceps, 25.* Vectis, 59.

	Presentations.
25	Breech
6	Feet
26	Face to Pubes
5	Face
1	Breech and arm
1	Hand and arm
1	Knee
1	Hand
2	Placenta
3	Breech } in twins
2	Feet } in twins
1	Hand and arm } in twins
1320	Natural
1394	Total.

Instruments used		
In 1st Labours	..	42 times.
2nd	.... ..	11
3rd	.... ..	9
4th	.... ..	6
5th	.... ..	6
6th	.... ..	2
7th	.... ..	2
8th	.... ..	3
10th	.... ..	3
Total		84

Deaths, 14.

Hemiplegia.	Consumption.	Hæmorrhage.	Uterine Disease.
1	2	1	1

Puerpl. Peritonitis.	Influenza.	Diffuse Infl. of cell. tissue of Pelv.
7	1	1

1.	Instruments used	1 in	$16\frac{3}{5}$ Cases.
2.	Unnatural Presentations ...	1	19
3.	Breech	1	$49\frac{11}{14}$
4.	Face to Pubes	1	$53\frac{3}{5}$
5.	Footling	1	$174\frac{1}{4}$
6.	Face	1	279
7.	Placenta	1	697
8.	Stillborn Children	1	$19\frac{5}{8}$
9.	Mortality in Mothers, exclusive of cases of Consumption ...	1	$114\frac{3}{4}$
10.	Twin Cases	1	81

* In five of the Forceps cases, the Vectis had been previously tried without effect.

Analysis of 4320 Cases reported by Mr. Earle, of Cromer, a marine district, in the Provincial Journal for June 10th, 1846.

No. of Cases, 4320.

Preternatural Presentations ...	178	or 1 in	24¼
Forceps	32	1	135
Arm Presentations	30	1	144
Shoulder	4	1	1080
Legs and feet	40	1	108
Breech	41	1	105⅜
Hip	13	1	332⅓
Chest	2	1	2160
Belly	2	1	2160
Side	2	1	2160
Ear	2	1	2160
Face	4	1	1080
Placenta	22	1	196⅖
Mortality to Mothers	17	1	254⅛
Twin cases	53	1	81½
Monstrosities	11	1	391⅕
Convulsions	8	1	540

Analysis of Cases published in Vol. 2 of Medical Gazette, p. 782, by G. Mantell, Esq., of Lewes.

No of Cases, 2410.

Arm	1	in	602½
Turning necessary ...	1		301¼
Forceps	1		401⅔
Embryotomy	1		803⅓
Convulsions	1		401⅔
Mortality	1		1205

Analysis of Cases reported by C. Rose. Esq., in Provincial Transactions, Vol. 7, p. 315.

No. of Cases, 600.—No. of Children born, 610.

Preternatural Presentations ...	18	or 1	in 34
Viz., Breech	9	1	68
Feet or knees	7	1	$87\frac{1}{7}$
Arm or elbow	2	1	305
	18		
Face	1	1	610
Funis	2	1	305
Convulsions	2	1	300
Accidental Hæmorrhage	18	1	$33\frac{1}{3}$
Unavoidable ditto	2	1	300
Stillborn Children	34	1	18
Twin cases	10	1	60
Mortality	4	1	150

Analysis of 2819 Cases—Mr. Bailey, Thetford.

Cases, 2819.—Children, 2860.

Preternatural Presentations ..	50	or 1 in about	$56\frac{1}{3}$
Breech	14	1	$204\frac{1}{3}$
Feet	29	1	$98\frac{9}{14}$
Arm	7	1	$408\frac{4}{7}$
	50		
Face	15	1	188
Funis	9	1	$313\frac{8}{9}$
Accidental Hæmorrhage ..	56	1	$50\frac{19}{56}$
Unavoidable ditto	5	1	$563\frac{4}{5}$
Convulsions	11	1	$256\frac{3}{11}$
Still-born Children	32	1	$89\frac{1}{8}$
Twin cases	41	1	$68\frac{3}{4}$
Mortality	4 }	1	$704\frac{3}{4}$
And from Consumption ..	5 }	or	$313\frac{8}{9}$

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Analysis of Cases published by Mr. Waddington, of Margate, in Vol. 34 of Medical Gazette, p. 144.

Cases, 2159.—No. of Children, 2180.
Males, 1136—Females, 1044—2180.

Twin cases	19		
Triplet	1		
Forceps	1	in	449
Mortality	1		1079½

Analysis of 1135 Cases in the practice of Dr. Toogood, of Bridgewater; reported in the Provincial Journal, vol. 8, p. 103.

No. of Cases, 1135.

Face to Pubes	8	or 1	in 142
Arm	3	1	378⅓
Breech	11	1	103⅓
Feet	3	1	378⅓
Placenta	1		
Forceps	15	1	75⅔
Perforator	6	1	189⅙
Twins	12	1	94½
Hæmorrhage	21	1	54
Adhesion or retention of Placenta	24	1	47·2
Phlegmatia dolens	1		
Mania	1		
Ruptured Vagina	2	1	567½
—— Uterus	2	1	567½
Peritonitis	2	1	567½
Convulsions	1		
Mortality	9	1	126⅑

Analysis of Cases reported in Vol. 8, p. 416, of Provincial Journal, by Dr. J. Lee, of Market Bosworth.

Cases, 850.

Funis	2	or 1	in	425
Breech	5	1		170
Lower extremities	13	1		65·3
Face to Pubes	5	1		170
Placenta	4	1		212·5
Arm	3	1		283·3
Twins	9	1		94·4
Adherent Placenta	5	1		170
Convulsions	2	1		425
Previous Hæmorrhage ..	5	1		170
Hæmorrhage after Labour ..	7	1		121·4
Mortality	2?	1		425

Analysis of Cases reported in the 8th Vol. of the Provincial Journal, p. 558, by Kenrich Watson, Esq., of Stourport.

Cases, 800.

Premature	12	or 1	in	66·6
Twins	18	1		44·4
Face	14	1		57·14
Breech	11	1		72·7
Arm, &c.	11	1		72·7
Dangerous flooding	27	1		47
Convulsions	4	1		200
Ruptured Vagina	3	1		266·6
—— Artery in Labia Pudendi ..	1			
Craniotomy	12	1		66·6
Severe flooding after extraction of Placenta	2	1		400
Mortality	7	1		114·28
Natural Labours	695			

In my own practice, in a tolerably healthy country district, 1290 Cases of Midwifery were attended in ten years, from 1835 to 1845; of this number, 253 were attended by my late partner, Mr. Taylor, one of which he lost by hæmorrhage immediately after delivery. The following is an analysis of the remaining 1037.

No. of Cases, 1037—No. of Children, 1046.

Vectis used in	108	or 1	in about	$9\frac{3}{4}$
Craniotomy	2	1		$518\frac{1}{2}$
Preternatural presentations	41	1		$25\frac{1}{2}$
Breech	13	1		$80\frac{1}{2}$
Footling	10	1		$104\frac{3}{5}$
Face	7	1		$149\frac{3}{7}$
Placenta	2	1		$518\frac{1}{2}$
Funis	5	1		$207\frac{3}{5}$
Upper extremity	4	1		$261\frac{3}{4}$
Convulsions	3	1		$345\frac{2}{3}$
Accidental hæmorrhage ..	5	1		$207\frac{3}{5}$
Still-born Children	42	1		25
Twins	9	1		$115\frac{2}{9}$
Mortality to Mothers* ..	1	1		1037

* If Mr. Taylor's Cases be included, the mortality would be 1 in 645.

Analysis of Cases reported by Dr. Ramsbotham, from the Eastern District of the Royal Maternity Charity, London, from January, 1831, to December, 1843; Medical Gazette, Vol. 34, p. 620.

No. of Cases, 35,743.

No. of Children, 36,131—Males, 18,610—Females, 17,521.

Excess of Males nearly 3 per cent.

Twin cases ..	386	or 1 in	92·6
Triplet	1		
Forceps ..	49	1	729·4

Head Presentations, 35,096, of which 141 were face, and 6 ear.

Face ..	141	or 1	in	248·9	in head cases.
Ear ..	6	1		5849·3	

Breech, or some part of lower extremities	930	or 1	in	38·8
Transverse ..	105	1		340·3
Still-born ..	2263	1		16
Placenta ..	40	1		893·5
Accidental hæmorrhage	116	1		308·1
Hæmorrhage after delivery ..	72	1		496·5
Convulsions ..	31	1		1153
Apoplexy ..	1			
Craniotomy ..	38	1		940·3
Mortality from Puerperal causes ..	126	1		283·67
Premature labour induced ..	20	1		1787·1
Ruptured Uterus	8	1		4467·9
Deaths from Hæmorrhage	56	1		2·25 of deaths.
		1		638·27 of deliveries.
In the 40 cases of Placenta presentations, 32 Children were still-born		1		1·25
Monsters ..	20	or 1	in	1806·5

Analysis of Cases in the practice of Janson, of Ghent, in 41 years. Medical Gazette, vol. 25, p. 893.

Cases, 13,365—Children, 13,439—M. 6611—F. 6828.

Excess of Females about 6 per cent.

Forceps	341 or about	1 in	39·2
Footling	150	1	89·5
Hand	30	1	448
Breech	97	1	138·5
Face	15	1	895·9
Funis	86	1	156·26
Placenta	7	1	1909·3
Craniotomy	5	1	2673
Symphysis Pubis divided	1		
Ruptured Uterus ..	1		
Superfœtation	2	1	6682·5
Convulsions	3	1	4455
Accidental Hæmorrhage	4	1	3341·2

Mortality not stated.

	Cases.	Deaths.
Private	1377	12
—	4320	17
—	2410	2
—	600	4
—	2819	4
—	2159	2
—	1135	9
—	850	2
—	800	7
—	1290	2
Public	35,743	126
	53,503	187

Or 1 in 286·11.

In 35,743 cases in public practice, the mortality was 1 in 283·67.

In 17,760 cases in private practice, the mortality was 1 in 291·14.

In 13,365 cases, the mortality is not stated.

Although I might have introduced a much greater number of tables, the foregoing appear sufficient to shew pretty clearly the average of the various occurrences in Midwifery. They include 17,760 cases in *private* practice; and it is curious to observe how little difference there is in the rate of Mortality in the number of private cases, and in the practice of the Royal Maternity Charity reported by Dr. Ramsbotham; the average of the whole number, public and private, is 1 death in 286·11—in private practice alone, 1 in 291·14—in the Maternity Charity, 1 in 283·67. But, notwithstanding this general approximation, it is extraordinary to see how much difference there has been in the practice of different individuals; the lowest proportion of deaths being 1 in 1205 cases; and the highest 1 in 114·28. It is difficult to account for such a wide difference as this; it cannot be owing to the superiority of one Practitioner over another; neither does the rate of mortality bear any definite proportion to the use of Instruments. I apprehend the chief causes of the low rate of mortality are the salubrity of the district in which the practice is carried on; the beneficial effects of country air and rustic habits, with cleanliness and temperance; and the less congregated abodes of the patients. On the other hand, residence in a city or large town, with the consequent poverty, unhealthy employments, want of cleanliness, and intemperate habits to which many of the inhabitants of thickly populated districts are obnoxious, seem to point out the reasons why, in such localities, the value of female life is more precarious.

The following summary, collected from the preceding tables, may be both interesting and instructive; and plainly demonstrates how much at variance, as to results, may be calculations founded upon small and large numbers :—

In 59,387 cases, Forceps or Vectis were used in 635, or 1 in 93·52.

In 54,490 cases, the Perforator was used in 66, or 1 in 825·6.

In 50,840 cases, there were 574 cases of Twins, or 1 in 88·57.

In 26,303 cases, the Breech presented in 226, or 1 in 116·38.

In 60,061 cases, the Face presented in 202, or 1 in 297·33.

In 25,503 cases, the Feet, or some part of the lower extremity, presented in 258, or 1 in 98·84.

In 28,713 cases, the Arm, or some part of the upper extremity, presented in 98, or 1 in 293.

In 18,671 cases, the Funis presented in 104, or 1 in 179·52.

In 61,246 cases, the Placenta presented in 85, or 1 in 720·54.

In 63,079 cases, Convulsions occurred in 71, or 1 in 888·43.

In 50,243 cases, Ruptured Uterus occurred in 11, or 1 in 4567·54.

In 40,063 cases, 41 Monsters were born, or 1 in 977·14.

In 55,214 cases, Previous Hæmorrhage occurred in 221, or 1 in 249·8.

In 37,393 cases, Hæmorrhage after delivery occurred in 81, or 1 in 461·64.

If these results be compared with the corresponding calculations in each of the preceding tables, it will be evident how incomplete any estimates must be that are based upon individual experience; and how necessary it is to make statistical calculations upon large numbers, and those not only large, but indiscriminately collected.

With respect to the employment of Instruments great variation is observable, and the result seems in favour of public practice; for in 35,743 cases in the Royal Maternity Charity, the forceps were used only once in 729·4 cases, and the perforator once in 940·3. My own cases

present the least favourable view, at first sight, of the use of Instruments; for it seems that the Vectis has been used 108 times in 1046 cases, or 1 in 9¾. In another part of the work, I have made a few observations on the use of Instruments in Midwifery, accounting, in some degree, for the frequency with which I have used the Vectis. I have further to observe, that I have employed it for rectifying the position of the head in cases where the face was inclined to turn towards the pubes; and have little hesitation in stating that it affords a valuable means for easily and safely guiding the occiput into its proper direction, in many cases of this nature.

From what I know of the practice of other Surgeons in the country, I believe instruments are much more frequently used by them than in towns or public institutions; and perhaps a reason may be found in the fact that, in healthy country districts, labour is more frequently prolonged by the large size of the children. Unnatural presentations are infrequent; deaths from puerperal causes rare; but prolonged and painful labours, from the large size of the children, are frequently encountered.

Yet, notwithstanding these explanations, the fact still remains, that I have used the Vectis more frequently than, from the average of a large number of cases, appears *needful.* I do not desire to advocate the use of instruments when they are not absolutely necessary, being fully aware of the *possibility* of their causing much severe and sometimes irreparable mischief; I can therefore only say in justification, that, in some instances, I have been implored to use the Vectis by patients who have before experienced its beneficial effects; that I have never seen a patient die whom I had subjected to its operation; and that I have never witnessed, in my own practice, the occurrences so frequently attri-

buted to the abuse of instruments, viz., ruptured Perineum, inflammation and sloughing of Vagina, Vesico-Vaginal Fistula, or any such prejudicial effect.

The first part of the following work contains a few remarks upon Abortion, followed by cases exemplifying the nature and treatment of that occurrence. The second part comprises a mass of information, through the medium of cases, interspersed with remarks, which, I trust, will convey to others the same amount of instruction which I am free to acknowledge, with thanks for the opportunity, they have already afforded to myself. From my knowledge of Mr. Crosse, and my experience of his constant desire to benefit the members of the noble profession to which he belongs, I feel I may take upon me to state, on his behalf, that it will amply repay him for the trouble of collecting, in the midst of extensive and responsible duties, the information now made public, to find it conducive to the comfort of his junior fellow-labourers, and contributive to the well-doing of those who are destined to undergo the pains and penalties of child-birth.

PART I.

ABORTION.

The subject of Abortion, or premature expulsion of the contents of the impregnated Uterus, is one of considerable interest, embracing many points relative to the health and safety of the patient, the happiness of parents, and the character and peace of mind of the medical practitioner.

It is a marvellous provision of Providence that Abortions, however threatening, do seldom prove fatal; and that females are enabled to bear, and recover from, greater dangers under such circumstances, than could be endured under many of the ordinary visitations of sickness. But this comparative freedom from danger in Abortions must not be relied upon to the neglect of acquiring full knowledge how to treat and render more safe this process; for cases do sometimes terminate fatally, and a perusal of the following will discover many instances in which the lives of the patients would in all probability have been sacrificed, had it not been for the opportune and well-directed interference of a confident and highly-experienced surgeon.

Although much has been written concerning the causes and varieties of premature labour, there is still

room for practical information upon the subject. There are, indeed, valuable directions and able remarks in the different works on Midwifery, but they probably occupy a single chapter only, or at all events, so small a space, compared with the whole book, that they often fail, amongst so much other matter more interesting to the student, to attract that degree of attention which their importance demands. The following cases, collected indiscriminately from the manuscript of Mr. Crosse, and the remarks which that gentleman has appended to them, point out sufficiently clearly what is required to be known upon the subject; and as I cannot suppose that observations of my own would add to their usefulness, I shall confine myself to the more simple task of condensing the information therein contained, as an inducement to, not a substitute for, an attentive perusal of the cases themselves.

Since many of the following cases occurred in consultation practice, there are more than the common proportion of severe cases: and it would be incorrect to base statistical conclusions upon them as to the comparative frequency of difficult or dangerous abortions. They shew, however, the ages and periods of pregnancy at which abortion usually happens: and for the purpose of impressing upon the minds of accoucheurs the possibility of meeting with difficulties, and the importance, nay the absolute necessity, of being armed with sufficient knowledge for every emergency, such a collection possesses great advantages.

As the *prevention* of abortion is frequently an object most ardently sought for by those who are desirous of having children, and of material consequence to the future health of the female who is unfortunately the subject of this derangement of nature's occupation, it is

necessary to understand the various causes which produce, in order to secure a fair chance of avoiding, the evil.

The causes may be divided into predisposing or exciting, and immediate; and the following division may be thought sufficiently correct for practical purposes. The *predisposing* causes are—

1. Sudden agitation from fear—depression of spirits—fatigue coupled with mental anxiety.
2. Bodily or muscular efforts, in pumping, lifting, &c.—falls or blows.
3. Imperfect conception—Mole—Hydatids.
4. Excessive distention of the Uterus.
5. Disease of the Placenta—Placenta prævia.
6. Other diseases, as Consumption, and all diseases producing great debility—severe Cough—Venereal disease—Dyspepsia—inflammation and other diseases of the substance of the Uterus—disease of os Uteri, of the Rectum or Bladder—Prolapsus Uteri—Small Pox—Influenza, &c—Plethora.
7. Coitus—Excess of Venery.
8. Abuse of purgative medicines.

The *immediate* causes are—

1. Death of the Fœtus.
2. Rupture of membranes and escape of Liq. Amnii.
3. Separation of Placenta, giving rise to Hæmorrhage.

The injurious effects of abortion are either immediate or remote; and of the former, hæmorrhage is by far the most frequent. Indeed, as far as my own observation extends, all the symptoms which immediately threaten loss of life depend upon loss of blood. Retention of urine, occasioned by the position of a partially expelled ovum or clot of blood, also sometimes happens as an effect of abortion; but the inconvenience is temporary, and danger is prevented by the use of the catheter.

The *remote* effects of abortion are more numerous, comprising all those diseases and nervous affections which are generally ascribed to the effect of loss of blood;—a habit in the Uterus of expelling its contents prematurely, which is sometimes so inveterate as not to be subdued by any mode of treatment;—various local diseases of the womb; and all such affections as usually result from debilitating causes.

The treatment of abortion naturally resolves itself into *precautionary* and *remedial;* the objects being to prevent miscarriage if possible; or failing this, to conduct the patient in safety to the completion of the abortive process. The obvious precautionary measures for preventing abortion, are the avoidance and correction of the various causes which appear to predispose the system to this derangement: and I need only refer to them as previously described, in order to point out the most probable means of relief. Against some of them little or no precaution can be taken—for instance, fear or mental alarm, as well as bodily accidents, will occur in spite of the greatest care; and when abortion is threatened by the existence of fixed incurable disease in the system, but little can be done to prevent it. The same may be said of imperfect conceptions, moles, hydatids, &c., which perhaps can be neither foreseen nor prevented. In many instances, however, there may be much done to avert the occurrence of abortion; and probably the best directions for the attainment of this desirable object are the following—

Rest, particularly in the recumbent posture.

Early hours.

Plain, nourishing, un-stimulating diet.

Occasional venæsection, if indicated.

Exercise in the open air, not amounting to fatigue.

Avoidance of all luxurious and debilitating habits.

Mattress in preference to soft featherbed, and light covering in bed.

Daily evacuation of the bowels, avoiding all powerful aperient medicines.

Cold bathing, if not otherwise contraindicated.

As a general rule, avoidance of sexual intercourse.

There is no rule without an exception; and whatever tends most to preserve the body in the best state of health, must be the most effectual means of averting abortion. The end is the same, but various means of treatment may be required for its attainment; and the tact and experience of the accoucheur will enable him to adopt, in each particular case, that general plan of treatment which the constitution of his patient seems to require.

Of the 100 cases reported, 2 occurred at 1 month; 3 between 1 and 2 months; 20 at 2 months; 10 between 2 and 3 months; 17 at 3 months; 7 between 3 and 4 months; 3 at 4 months; 1 between 4 and 5 months; 17 at 5 months; 2 between 5 and 6 months; 10 at 6 months; 4 between 6 and 7 months. In 4 the period is not mentioned.

Months.	1.		2.		3.		4.		5.		6.	
No. of Cases.	2	3	20	10	17	7	3	1	17	2	10	4

This table shews at what periods of pregnancy abortion is most likely to happen, and indicates the time at which precautionary measures are most likely to be required.

The curative treatment of abortions is of the greatest importance, since, if well understood, it rarely fails.—The frequent occurrence of premature labour without any dangerous symptoms, or even without requiring medical assistance, is perhaps calculated to convey the idea that

real difficulties never arise; but let those who would, from considerations such as these, neglect to render themselves competent to grapple with unforeseen difficulties, picture to themselves such cases as Nos. 37, 47, 48, 58, &c. occurring in remote country districts, where they would have to depend solely upon their own resources. In town practice, where cases of all kinds are more numerous, competent help is always at hand; but in less populated districts, ignorance may be fatal; and although a Judge may acquit a country practitioner of crime on the score of ignorance, and sanction the idea that much knowledge cannot be expected from village doctors, yet instances of life being sacrificed to incompetency, should rather prove that no improperly educated person ought to be allowed to practise *anywhere*, much less in localities where extraneous resources are not attainable—in those very villages where the *knowledge* of *the* doctor is the only protection to his patient and to his own peace of mind.

Let it not be thought that I am about to advocate interference in abortion as a general rule. Dr. Blundell's Remark, "Meddlesome Midwifery is bad," is not more applicable to any part of the subject than to this; and in the majority of cases nothing more than rest and recumbency are required. For instruction as to the management of cases which do really require manual aid, the following collection is valuable, and I shall endeavour briefly to lay down the rules which are therein inculcated. The greatest danger is from hæmorrhage, and it will be seen that, under extreme degrees of this accident, safety is to be insured by the prompt and scientific application of art.

When, at any period during utero-gestation, uterine pains occur, accompanied by bearing down and hæmorrhage, it may be considered that a stop will be put to the

further progress of pregnancy, and that the uterus is about to discharge its contents. When pain and uneasiness about the pelvis take place, *unattended with loss of blood*, abortion, though threatened, may frequently be averted, by enjoining rest in the recumbent posture, administering opiates, and securing regular evacuations from the bowels. There are also good authorities for asserting that pregnancy may go on to the full period, *even when hæmorrhage has occurred* if unattended with uterine pain. My own experience affords no instance of such continuance of pregnancy when hæmorrhage, to anything more than a trifling extent, has taken place.

When hæmorrhage occurs in conjunction with the usual signs of impending abortion, and continues sufficiently long, or is sufficiently active, to become an object of suspicion; or where, though the loss be trifling, the nature of the constitution is such as to be injured by it, an examination per vaginam is a proper and necessary proceeding; and although often resisted by the patient, should be firmly urged by the accoucheur. If, on examination, the ovum should be found projecting through the os uteri, and partially in the vagina, it should be gently drawn away with the fingers, and the hæmorrhage will in all probability cease. It is important, however, to be able to distinguish between the ovum presenting, and a clot of blood in the same situation; for should the ovum not be entirely separated from its connection with the uterus, a clot at the os uteri might act as a plug, and by removing this we might increase the hæmorrhage instead of preventing it. The directions for distinguishing the ovum from clots of blood, contained in Dr. Rigby's work, are so appropriate, that I cannot do better than transcribe them:—

"When the abortion is in the second or third month,

the practitioner must bear in mind that it may have been retention of the menses, and therefore what he feels in the os uteri may either be an ovum or a coagulum of blood. To decide this point, he must keep his finger in contact with the substance lying in the os uteri, and wait for the accession of a pain (for where clots come away, pains like those of labour are present), and ascertain whether the presenting mass becomes tense, advances lower, and increases somewhat in size; this will be the case where it is the ovum pressing through the os uteri. On the other hand, if it be a coagulum, which it is well-known assumes a fibrous structure, it will neither become tense nor descend lower, but be rather compressed. Generally speaking, the ovum feels like a soft bladder, and at its lower end is rather round than pointed, whereas a plug of coagulum feels harder, more solid, and less compressible, and is more or less pointed at its lower end, becoming broader higher up, so that we generally find that the coagulum has taken a complete cast of the uterine cavity. If we try to move the uterus by pressing against this part, it will instantly yield to the pressure of the finger, if it be the ovum ; whereas, the extremity of a coagulum under these circumstances is so firmly fixed, that when pressed against by the finger the uterus will move also. When abortion happens at a later period of pregnancy, we shall be able to feel the different parts of the child as the os uteri gradually dilates, viz., the feet, or perhaps the sharp edges of bones; although we cannot distinguish the form of the head, from the cranial bones being so compressed and strongly overlapping each other."*—(Hohl, on Obstetric Exploration.)

If, on examination, the os uteri be closed or nearly so, and nothing can be felt presenting at it, the proper means

* Library of Medicine, Vol. 6, p. 93.

of arresting hæmorrhage in the early months are—plugging the vagina—administering ergot—opium—applying cold—and, although in early abortions such a proceeding is difficult and generally to be avoided, cases 47, 48, &c. of the collection shew that, under certain extreme difficulties, the ovum may be artificially separated from the uterus and removed.

In the latter months, plugging the vagina is neither so effectual or safe, from the possibility of hæmorrhage going on within the more enlarged uterus, whilst its non-appearance externally may lull the practitioner into a false security, until it be too late to repair the mischief. But as a compensation for this, when hæmorrhage occurs severely in the latter months, and cannot be restrained by ergot, cold applications, rupturing the membranes, &c., manual interference is more practicable, from the larger size of the uterus, and may generally be rendered available for rescuing the patient from danger.

It frequently happens, that after a fœtus has been expelled, hæmorrhage is kept up by retention of the placenta; the nurse thinks all is right, because a clot has passed whose fibrinous appearance convinces her that it is the after-birth—still hæmorrhage goes on at intervals, until the patient is faint and exhausted; and the practitioner, when sent for, discovers the placenta partially expelled, and retained by the contracted os uteri; keeping up the hæmorrhage at the peril of the woman's life, and requiring but a very simple manual proceeding to remove it and ensure safety. The case of Seeley, No. 90, points out the extreme importance of placing no reliance upon the opinion of the nurse, when there are symptoms present which excite suspicion; and is well calculated to produce an indelible impression upon those who are desirous of escaping the evils which might

result from the neglect of personal examination *per vaginam*. Practical experience is indisputably a most important qualification in a medical practitioner; but if he depend upon this, to the exclusion of reading and studying the experience of others, he incurs the risk of discomfiture and disappointment, perhaps of losing the life of his patient, when called upon to treat diseases or to manage difficulties of rare and singular occurrence.

I forbear to enter more fully into a description of the treatment of abortions, feeling convinced that a careful perusal of the cases will afford the best instruction. The value of cases, properly reported, is the information they furnish as regards the minutiæ of treatment. A student or junior practitioner may say, "I am advised in such a case as I have now to manage, to plug the vagina, but how am I to set about it? I am advised to apply cold, but how long is it to be continued, and under what circumstances will its continuance prove injurious? I ought to remove this partially retained ovum, but how can I best accomplish it?" Now all these points, and many others worthy of notice, are explained in the following cases; and if the few preliminary observations which I have made, should induce any who practice midwifery to read them attentively, I shall feel certain of having rendered them assistance, by supplying them with information, which, some time or another, they may have occasion to value.

It may not be out of place here to remark, as a point deserving of further consideration, that in two cases of severe uterine hæmorrhage, one from tubercle of the uterus, and the other from suspected abortion, the loss of blood has been quickly put a stop to by injecting a pint of *cold* water into the rectum: these occurred in my own practice, and may possibly afford a hint for arresting

hæmorrhage by a method not usually referred to, and as far as I know, very seldom employed. Before I made use of it in my own cases, I had not seen it mentioned in books, but have since found it incidentally noticed. Might it not be more generally used with advantage, as a good method of applying cold in cases of uterine hæmorrhage? Might it not occasionally prevent abortion?

ABORTIONS.

1. Rudd, æt. 24. First pregnancy; 3 months gone. Fœtus beginning to be putrid. Sudden agitation from fear a week or two before.—"Death of fœtus the most common cause of early abortions."

2. Harvey, æt. 23. First pregnancy; 14 weeks. Mole. Pain commenced after exertion in pumping a fortnight before.—An imperfect conception leads to abortion, and such was probably the cause in this instance.

3. Hogg, æt. 28. Sixth pregnancy; 3 months. Spirits low, from embarrassed circumstances. Fœtus seemed to have been some time dead; voided frequently afterwards large clots of blood; had rigors and syncope. Found, 13 days from escape of fœtus, great part of placenta in vagina, which I removed.—After abortion at this period, if placenta does not come away, and clots of blood are discharged, with rigors and low fever, &c., the vagina should be examined, and placenta extracted if it be there.

4. Rudd, æt. 33. First pregnancy. 20 weeks since menstruation. Child alive when expelled. Placenta healthy.—Cause unknown.

5. Clarke, æt. 25. Second pregnancy; two or three months. Had discharge of blood for a month, coming on suddenly and reducing her much. Plugged vagina with lint, after which hæmorrhage ceased. 48 hours afterwards, removed the plug, and found putrid portions of fœtus and whole of placenta in

vagina, which I extracted.—Presentation of placenta was the cause of hæmorrhage.

6. Willey. Three months.—Attributes it to over exertion.

7. Warren. Two months.

8. Warren. Three months.—Cause unknown.

9. Curtis. Large family. Three or four children.

10. Flaxman. Three months. Fœtus appeared to have been some time dead.

11. Postle. Has had several children. About 6 months. Discharge of apparently matter per anum and tenesmus. After this ceased, miscarriage took place; fœtus beginning to putrefy.

12. ———, æt. 22. First pregnancy. At an early period was salivated, believing she had venereal disease. Miscarried of a 5 months fœtus, which had apparently been dead. Placenta in some degree disorganised.

13. Whurr. Has had several children. Flooded to faintness, and after many pains, voided a mass like placenta and membranes entire. It contained about ℥ j gelatinous fluid like white of egg, and no fœtus.

14. Jessup. Has had 7 children. Three months.—Cause unknown.

15. Rudd. About 5 months.

16. Collett. Had many children. Two or three months. Ovum passed entire.

17. Hipkins. Had 6 children. Supposed about 3 months gone. Abdomen enlarged rapidly beyond the size at full period. She was bled, blistered, &c., and pregnancy was doubted. No

general dropsy. She miscarried with twins, with enormous flow of water from uterus.—The rapid formation of fluid, and over distention of uterus, make this amount to something like dropsy of that organ.

18. Goodrick. First pregnancy ; about 5 months. Considerable discharge of clotted blood before fœtus came away.—Placenta came before the fœtus, and this perhaps might be the cause of the miscarriage. Child had been dead a long time.

19. Ellis. Two children. Two months gone ; had pains for 5 days, during which time she could not pass her water, and catheter was used. The mass was found projecting through the os uteri, and when this came away, the retention of urine disappeared.—This shews retention of urine to be one effect of miscarriage.

20. Rawlinson. Had several children, and always flooded greatly after delivery. Two months gone. Hæmorrhage requiring plugging and application of cold vinegar and water. Placenta looked unhealthy.

21. Vincent. Had several children. Four months. Child had been dead some days.—No other cause than mental alarm.

22. Mann. Had several children. Pain and coloured discharge for a fortnight ; then premature labour at 6 months, with a dead child. —Possibly separation of the placenta might be the cause of the child's death, and subsequently of the premature labour.

23. Byford. Second child. About 7 months' child, which appeared to have been dead a week or more, and this was the cause of the miscarriage.

24. Daynes. Supposed 5 months gone ; suffered from fright 5 weeks before miscarriage ; fœtus dead as long.—I found large coagula in the placenta, as if bleeding had occurred from rupture of a vessel into it ; which I conceive may be one cause of death of fœtus and of miscarriage.

25. Smith. Third pregnancy; 5 months. Had coloured loss for 6 or 8 weeks, so as to reduce her very considerably; child dead some time.—I believe loss of blood, perhaps on account of separation of the placenta (which was not at the os uteri), was the cause of the death of the fœtus and subsequent miscarriage.

26. Steel. Second pregnancy; 5 months. Child had been dead about four days, according to her sensations.—Cause unknown.

27. Nevill. First pregnancy. Ovum came away entire; about 6 months gone.—Cause unknown. No fœtus to be found in the entire membranes.

28. Dawson. Second pregnancy; 3 or 4 months.

29. Funnell, æt. 30. Third pregnancy; 2 months. Loss for 2 or 3 days; then a mass passed, having the form of uterus, with a cavity enclosed by membranes, but no fœtus.*

30. Doughty. Second pregnancy; 6 or 8 weeks gone. Contents of uterus were hydatids attached, varying from the size of a pin's head to a pea or kidney bean; and a fœtus at the lower part.*

31. Wheelhouse, æt. 34. Second pregnancy; about 2 months. Not in health.

32. Morris, æt. 25. Third pregnancy; miscarried 3 months ago, and again now; about 6 weeks gone. Has a cough and is feeble; no other assignable cause.

33. Phillips. Delicate, subject to cough and chest affection; miscarried twice with an interval of little more than two months. Could not trace the cause, beyond the delicate state of her health.

* Cases 29 and 30 shew, what most of my observations have tended to prove, that abortions not produced by death of fœtus, but occurring at 2 or 3 months, are often from disease or defect in the placental mass, or a mole, or an imperfect conception.

34. ———, æt. 42. Had several children; 6 or 7 months gone. Much reduced by flooding, os uteri not open, and no possibility of detecting if placenta were there. Hæmorrhage ceased; she diminished in size, and three weeks after miscarried without any hæmorrhage. Fœtus small and apparently not more than 2 or 3 months old. Placenta large and full of projections, which may be regarded morbid. The fœtus must have died, and the placenta have grown afterwards.

35. Playford. Two or three children; 2 months gone. Fatigue in attending her husband in severe illness from carbuncle.

36. Tinckler, æt. 35. Was regular 4 months ago. Body as large as at 7 months. Had pain and loss of blood, and next day I felt the feet of a small fœtus projecting through the os uteri. A few hours afterwards the fœtus, semi-putrid from having been some time dead, was expelled, followed by an after-birth six times as big as the fœtus, and large enough to fill a quart mug; part of this mass had the usual placental structure; the rest being made up of hydatids hanging by footstalks like grapes, and varying from a pea to a pigeon's egg in size. Then there was a swelling on back of neck and occiput of fœtus; and on cutting through the skin, I found several similar hydatids the size of marbles. The patient had a great deal of fever for several days, with rigors, red tongue, and small rapid pulse. A fortnight after abortion she had a great loss of blood per vaginam. Subsequently she had pain in her left arm and elbow, with swelling.

37. Hunt, æt. 34. Twelfth pregnancy; 5 or 6 months gone; had pains during the day, and after being in bed at night had a profuse loss, was pallid and cold, and pulse just perceptible; uterine pains every few minutes. I introduced my hand into the vagina, and could get the finger into the os uteri, and feel the placenta there; but it could not dilate enough, nor indeed were the parts large enough to allow me to make an attempt at delivery. In consultation it was agreed that plugging was the only plan; so I filled the vagina with lint or linen. The placenta at os uteri at between 5 and 6 months of utero-gestation, here seemed to threaten to be fatal by flooding, and certainly no delivery

could be effected. Opiate. Next day I drew off the urine, the plugs, by pressure, preventing it being voided. There had been no loss, and the patient, by horizontal posture and nourishment, was much recruited.—In six days no loss of blood, but fluid escapes as if Liq. Amnii was being discharged; the plugs are away; she got well; no continuance of pregnancy.

38. Label. Had prolapsus uteri; became pregnant, and miscarried at 3 months. Said the uterus had been prolapsed only a fortnight before her miscarriage; proving that this can take place when pregnancy is advanced more than two months.

39. Harrison. First pregnancy; 1 month gone.

40. Wilkin. Second pregnancy; 1 month. Attributed to over-exertion.

41. Durrant. Several children and several abortions; between 2 and 3 months.—Cause unknown.

42. Staffe, æt. 30. Two months. Ovum entire.

43. Evans. Suckling a child 1½ year old; miscarried at 5 or 6 weeks, having fallen pregnant whilst suckling, and without having menstruated.

44. Ralison, æt. 40. First pregnancy; 2 months.—Could not find a proper fœtus in the ovum expelled.

45. Wilde. Seven children. Flooding at 3 months; no fœtus to be found in the membranes, though these were entire and the liq. amnii clear. There were 2 or 3 small white bodies loose and floating in the liquor, which might be the detritus of the fœtus; for I can only explain this state, by supposing that the fœtus dies and dissolves in the liquor; or I rather suppose this, than that the fœtus should originally be wanting.

46. Smith, æt. 30. Ninth pregnancy; 5 months. Funis hung out of labia; child's feet at os uteri; os uteri gave much re-

sistance to the head. Funis broke and I left the placenta. There was no hæmorrhage, and very little discharge of any kind till three days after, when she had uterine pains, lost so much by flooding as to be pallid and exhausted, when I was called. Felt the placenta protruding through os uteri, and removed it entire.

47. Blyth. Several children; was so much reduced by flooding, when three months gone, that she was pale as a sheet, bloodless, and in danger. I was able with fingers to detach all the ovum from the uterus, and to remove chief of it, and the loss ceased. She soon recovered.*

48. Similar to the last. Brought away chief of the placenta; plugged up the vagina with lint dipt in solution of alum. Recovered.*

49. Neale, æt. 22. First pregnancy; 5 months. Fœtus perfect and alive when born.—Cause unknown.

50. Ribbans. Several children; 3 months. Fourth miscarriage since she last bore a child.—Cause unknown.

51. Murton. Second pregnancy; between 5 and 6 months. Began by waters breaking, and labour terminated 12 hours after; feet presented; child dead, but perfect.

52. Cox. Fifteenth pregnancy; between 3 and 4 months. Fœtus passed, but placenta did not follow. Flooding; cold and usual remedies applied. I found patient chilly, nay cold as ice; countenance, lips, pale as a sheet; pulse scarcely perceptible; sickness; vomiting for several hours part of every thing taken; violent retching. She had fainted, and had a shivering fit, which created the alarm that led to my being sent for. The hæmorrhage was a gradual oozing, and I knew the placenta could not have passed away, else the hæmorrhage would have ceased. The patient had not been examined; but on doing so, I found the placenta chiefly in the vagina, a part of it lying in and keeping open

* In each of these cases I should have found a pair of forceps facilitate the removal of the ovum; but mischief might be done with them in rough hands.

the os uteri. It was removed without difficulty. A little weak brandy and water given at short intervals. The hæmorrhage was trifling afterwards ; the vomiting ceased after three hours ; in six hours, and not sooner, the surface of the body was warm ; the pulse had rallied ; the faintness subsided ; colour of lips returned. The patient, from this time, went on well.

53. ———. Several children. Six months. The infant breathed and lived an hour or two.—Feeble and relaxed habit.

54. Newton, æt. 40. Six weeks.—Cause unknown.

55. Bandon, æt. 30. Four or five months.

56. Gardiner, æt. 30. Several children. Ten weeks. Hæmorrhage profuse. Enjoined cool nourishment, rest, horizontal posture, mineral acids, &c. Found coagula in vagina, but no ovum at os uteri. At night large coagula had passed, and also a mass, 3 or 4 table spoonfuls, of hydatids, the largest the size of peas.

57. Debbage, æt. 25. First pregnancy ; 10 weeks. Ovum passed entire, after loss of blood for several days.—Cause unknown.

58. ———, æt. 29. Fifth pregnancy ; between 6 and 7 months. Fell down and received a blow on left side of abdomen, midway between the navel and left superior anterior spinous process of ilium. From this, she began to flow till she was faint. Four surgeons saw her in the course of the day, and after nine in the evening I was called. Two had been trying to deliver, but the others thought she would die under the attempt, and that at so early a period of pregnancy it was improper to make it. Altogether 4 lbs. blood lost ; constant sickness and vomiting from time of the accident ; pulse imperceptible ; heart's action not to be felt ; cold clammy skin ; indeed she was thought to be near dying ; but scarcely any loss for five hours. Os uteri admitting only tip of finger ; head of fœtus to be felt through the uterus, just behind the pubes, proving the uterus was not ruptured through, as

I had, from the symptoms, at first thought. There had been great pain in the seat of the injury, but the body now bore pressure there, which it would not have done if a rupture of the uterus had taken place. I advised not to deliver, particularly as no loss for five hours. I thought it would be fatal to proceed in such a measure. I mentioned rupturing the membranes (the placenta was not at os uteri nor within reach, though the loss was doubtless from partial separation of placenta), but it was not done. Brandy and water. She rallied, and I learnt a few days after, she did well. About 14 or 16 days after the accident, this woman was delivered of a dead child; the cuticle detaching, shewing it had been some time dead, and Mr. —— believed that it had died at the time of the dangerous loss after the flooding.

59. More, æt. 24. First pregnancy; 3 or 4 months.—Waters broke without any disease of fœtus or placenta, and led to the miscarriage.

60. Giles, æt. 25. First pregnancy; 4 months. Cause unknown. The pain commenced after being in bed at night.—Was coitus the cause? or a sudden fright to which it is with little reason attributed?

61. ———, æt. 26. Second pregnancy; 6 weeks.—Loose character.

62. Carey. Three or four children. Ten weeks. Ovum entire.

63. Coe. Five months.—No assignable cause.

64. Giles. Second pregnancy; 4 months. Placenta came away two days afterwards, after considerable hæmorrhage.

65. M——. Five months. Fœtus had been dead several days. Could not ascertain the death of the fœtus.

66. Harvey, æt. 30. Fourth pregnancy; five months.—Healthy fœtus. No assignable cause.

67. Page, æt. 35. Several children. Between 2 and 3 months. After some fatigue, profuse loss; and to know if the placenta were away, I examined. Did not feel it, but felt one lip of the os uteri very large, thick, prominent, rough on the surface, impressing me with the belief that an ulcerated tumor was situated at the os uteri; but no preceding pain, nor loss till within a few days, had occurred; general health quite good; all contraindicating any preceding disease. But it suggested to me, that disease of os uteri may be one cause of abortion.

68. Giles, æt. 28. Third pregnancy; about 5 months. Third miscarriage.

69. ——— æt. 36. Several children. About 6½ months. Dead fœtus expelled, and with it the placenta. I regard the death of the fœtus as the determining cause of the premature delivery. Some hæmorrhage continuing, and the patient being faint, Mr. P. introduced his hand into uterus, and from what he felt, doubted whether there was not another fœtus. I found uterus contracted; no second fœtus; but at the posterior part of the uterus, just within the os uteri, I felt a prominent and flabby part of the organ, which I judged to be the spot where the placenta adhered.—Recovered.

70. Page, æt. 40. Several children. Fourth miscarriage; 2 months.—Cause, partial separation of placenta?

71. Chittle. Fourth pregnancy; 2 months. Disordered stomach.

72. Norris, æt. 30. Fourth pregnancy: between 2 and 3 months. Loss went on for 36 hours, until she was faint, and pulse imperceptible, creating in my mind alarm about the result, particularly as on examining, though I could get the finger into the os uteri, no ovum was protruding there so as to enable me to extract it. I plugged up well the vagina with folds of linen, not having lint at hand. This prevented the urine being evacuated, and I was obliged to use the catheter; the loss, however, was stayed, and by giving a little stimulus and plenty of nutriment,

which the stomach well retained, her powers rallied; some pains went on, and when plugs had been in above 24 hours, I removed them; found the ovum nearly expelled from uterus into vagina, so I with fingers got it out of os uteri completely, and then removed it from vagina.*—Recovered.

73. H——. Fifth pregnancy; 10 weeks. Phthisical.

74. Norris. Fifth pregnancy; 2 months. Removed the ovum from the vagina. The cause I assign is "feebleness of system, great irritability and nervousness."

75. Wilson, æt. 22. First pregnancy; 5 months.—Supposed to arise from powerful action of purgative medicine a few days before.

76. Waite. Fourth or fifth pregnancy. Feeble system. Five months gone.

77. Grew, æt. 42. Two months. Hæmorrhage going on above 24 hours; uterine pains; pints of blood lost; great pallor and pulse just perceptible; sickness. I removed a large clot presenting in the vagina, but could not feel the ovum; but two hours after, the ovum was projecting at the os uteri, and I succeeded in removing it with my fingers; after this, the hæmorrhage ceased and the patient gradually recovered.†

78. Holmes, æt. 20. First pregnancy; nearly 3 months. Severe uterine pains recurring often and had been for 8 or 10

* When, under extreme loss, you cannot remove the ovum, and ergot does not succeed in either arresting the hæmorrhage or expelling the ovum, you must plug the vagina to give temporary stay to the hæmorrhage, that a little time may be allowed for recruiting the patient; and during this time, often the uterus will expel the ovum into the vagina, though it must stop in this passage on account of the plugging.

† This case shews strongly the necessity of examining and of removing the ovum when you can. Had I not examined, or not taken steps to remove the ovum projecting at the os tincæ, the hæmorrhage would no doubt have continued, and might have proved fatal.

hours; considerable loss and some clots. Found the ovum projecting at the os uteri; by pulling on the perineum at the time of a pain, and dilating thus the external parts as well as exciting more expulsive effort in the patient, I have no doubt I expedited the expulsion, which was accomplished about an hour after I arrived.

79. Waite. Delicate constitution. Two months.

80. Mrs. ——, 9 living children, informed me, that in her sixth pregnancy, when three months gone, she miscarried of a fœtus of that age; and at the expiration of six months more, she was delivered of a healthy 9 months child: proving that she was pregnant with twins, with one of which she went the full term, losing the other by abortion at three months.

81. Wilson, æt. 25. Second pregnancy; 3 months. A fall from a chair.

82. H——. Fifth miscarriage; 3 months. Fœtus had been dead some days.

83. D——, æt. 37. Three months. The head of fœtus being within the os uteri, separated from the body on my pulling away the latter, which occupied the vagina; foot presentation; fœtus semi-putrid, had been dead some days. Had severe cough and cold 10 or 12 days before the abortion, which might have caused separation of placenta and death of fœtus; besides this, I know not what conjecture to form as to the cause of the *death of the fœtus*, which was in this, as in a majority of cases I believe, the cause of the premature expulsion.

84. Curteis. Six months. Loss and faintness without pain. In 2 or 3 hours, pains came on; loss ceased. A fœtus, evidently dead some hours, was born, and placenta soon followed. Was separation of the placenta the cause of the death of the fœtus? The symptoms which ushered in labour would indicate it.

85. Bailey, æt. 35 years. Several children. Delicate,

nervous, emaciated, pallid. Miscarried at 2 months, but her surgeon was not convinced whether it were a miscarriage or purely menorrhagia; the loss was great, reducing her feeble system excessively. Mr. W. immediately adopted the refrigerating system, cloths dipped in cold lotion to the region of the uterus and labia; open windows and curtains; cold mild drinks only; no fire; besides which, aperients were given; lowish diet, and Inf. Ros. with acid. Sulph. dil. After this system had been continued above a week, the menorrhagia still going on in a degree, I was summoned owing to the distressing and threatening symptoms; hysteria, with ball in the throat; excessive difficulty of breathing; convulsive tremor of limbs; stammering, so that she could scarcely articulate; no locked-jaw however; vomiting; diarrhæa; the state was really threatening; and the view I took was that the excessive refrigerating treatment was injurious, and had caused the most distressing symptoms; the windows were still open; only cold drinks had been offered; no fire allowed, though in October and the nights frosty; I changed the measures, but gradually, with a view to restore warmth and power of system; closed windows; had a small fire in the room at night; allowed a covering of blanket; a starch opiate injection to quiet the bowels; a little warm tea, broth, jelly, Ext. Pap. Alb. at night; an effervescing dose and a mild bitter as tonic; clean dry napkins. In 18 hours there was scarcely a stain on the napkins; warmth of system had returned, and before it the hysterical symptoms had in a great degree vanished. The hysterical attacks returned a few times; and there was occasionally severe convulsive tremor of the limbs; but these ceased, correct speech was regained, and indeed recovery speedily established under a select nutritious diet and Liq. Cinchonæ.

86. Mrs. ——. Several children. Two months gone. Had lost much; was very faint: still sitting up. I found the ovum projecting at os uteri, and was able with my fingers to draw it away; directed recumbency, and she ceased to lose.

87. Priest, æt 40. Several children. Nine weeks. Loss had gone on 12 hours very profusely when I was called; found her quite

pallid, still os uteri inaccessible. I gave sulph. acid and opiate; the loss continued all night, with occasional uterine slight pains. I could get finger into os uteri next morning; could feel placental mass, but none projected into vagina; the faintness was so great, and the loss had been so profuse, that I much feared a fatal result. I filled vagina with shreds of calico (after clearing out all coagula), and gave a pill of Extr. of Ergot every hour to produce expulsive uterine pains. In six hours more, the os uteri was so open that the ovum projected into vagina enough to allow of my seizing it with forceps, and I brought it away entire; after which there was no more loss, and the patient recovered.*

88. C——. Second miscarriage; five months. A dead fœtus expelled after five hours of uterine pain; it had probably been dead a fortnight, as at this period back she took fright; had not since felt the child move as she had before; and experienced a coldness in the lower part of abdomen; there can be no hesitation about assigning fright as the cause of death of fœtus in this case, and the death of fœtus as the cause of premature delivery. The result of the fright was probably not separation of placenta, and thereby death of fœtus, for the placenta appeared *fresh*, and as if it had recently adhered. I know not, however, if this remark is to be trusted.

89. Drewell, æt. 29. Sixth pregnancy; 5 months. Some hæmorrhage for 2 or 3 weeks, which now returned with some uterine pain; and on account of loss being considerable, I was called—we agreed to advise plugging the vagina with lint soaked in solution of alum, and to wait; as, in so early a period, delivery could not be effected by hand, should hæmorrhage and placenta prævia indicate it. I advised, moreover, that should hæmorrhage recur, the membranes should be ruptured. I could feel child's head through the uterus, but not ascertain that

* This case points out a fit opportunity for using Ergot; also the means of removing the ovum by forceps. It was almost the severest case I have ever attended of hæmorrhage with abortion, and I really apprehended loss of life; but at this period of pregnancy, it seems that gradual loss may go on to an extreme degree of exhaustion, pallor, sickness, almost syncope, and the patient resist and rally at last.

there was placenta prævia. She was delivered of a dead fœtus 30 hours after I saw her, without any considerable loss.

90. S——, æt. 33. Seven living children. Eleventh pregnancy; between 3 and 4 months. Began to flow on a Sunday, continued to lose daily, and on following Friday the fœtus passed, but no membranes. The loss still went on, and on Sunday following a surgeon was sent for, who gave some general directions, but did not examine per vaginam. Daily loss continued until the patient was brought to the following state, 15 days from the commencement of the loss, and 10 days after the birth of the fœtus, viz., pulse scarcely to be felt; constant call for cold water to sip; emaciated body; the greatest prostration and almost syncope, clearly from continued loss of blood, till the system was nearly bloodless; putrid coagula lodged in the vagina, and as they escaped gave a most offensive stench in the room. Mr. —— had been there before me, but never examined per vaginam since first called, believing the old woman's account that the after-birth had passed away early this morning. The window was open; patient covered only with a sheet, drenched in cold vinegar rags; bed already spoiled from the moisture and hæmorrhage. On examining, I found the placenta projecting at os uteri—the external parts were enough relaxed, and I found it easy to introduce a finger into the os uteri and remove the placenta, which seemed to me to be still adherent in one part to the uterus; and indeed there is other reason to think the placenta had continued in part adherent, as it was not putrid. I removed it with finger and thumb; from this time the hæmorrhage ceased. Brandy had been already ordered. I took care to place dry linen under her; to cover her lightly but sufficiently; got the stomach to bear a little milk and water, and a morsel of bread and butter; and by degrees, in the course of the next 36 hours, she rallied; the stomach was able to bear food better and better, and no doubt was felt as to her recovering from the alarming state to which she had been brought purely by loss of blood.

It is surprising that in this case, the surgeon, a well-informed man and experienced, did not examine per vaginam, during the several visits he made. As the loss continued at his first visit, three days after the fœtus had passed, he should then have ex-

amined; but I believe his negligence in this respect is to be accounted for,—1st, from his never having, as he states, known a case of miscarriage fatal from hæmorrhage. 2nd, his impression that no manual assistance can be given at so early a period of utero-gestation, when abortion is impending, and attended by hæmorrhage. Supposing there were no risk of death, profuse extreme loss of blood is not harmless, and ought not to be incurred if avoidable. Do not books on abortion treat of the necessity of examining? The propriety and practicability, under certain circumstances, of giving manual aid? The necessity of plugging the vagina, if the ovum be still in utero and inaccessible? Is ergot recommended in such cases? I should add, that when I met Mr. ——, the day after I removed the placenta, I advised washing out the vagina by a syringe and plenty of water, to remove putrid coagula; it is desirable to get rid of these, which, lodging long in vagina, may cause future mischief, foul discharge, &c.; facilitating inflammation, ulceration; even laying the foundation of incurable ulcer of os uteri.—The patient rallied and recovered.

91. Blazeby. Four or five living children. Six or eight weeks gone. Slight loss, recurring several times at intervals of several days each; then the loss continued and considerable; and when I was called, it had been profuse, soaking the bed as well as bed-clothes. I found the ovum at os uteri, and was able, with my finger and thumb (hand being in the vagina), to remove the ovum entire. After this the hæmorrhage ceased, but the patient went into a state of syncope after I left; and I returned and gave stimulus till she rallied. She was still pallid at the end of ten days, and scarcely restored in a fortnight. The ovum shewed signs of not being fresh, and on opening the membranes, I found no trace of fœtus or funis; the contained liquor was turbid rather, and my explanation is that from some cause the placenta became detached in part or principally from the uterus when loss first appeared—that the fœtus died in consequence and putrefied away in the liquor, thus accounting for no trace of fœtus on examination. The abortion became necessary after fœtus had died and membranes undergone a degree of putrefaction.

92. Turner. Fourth or fifth pregnancy; near 3 months gone. Took a long walk, felt pain and bearing down before she reached home; had a slight loss. All these symptoms continued for three days, then came considerable loss; large clots. In course of last night severe uterine pains; faintness from loss of blood; I found the ovum in vagina, a small part still being in os uteri. I removed the ovum and coagula, by introducing my hand into the vagina. The membranes were entire, size of a small hen's egg, but there seemed to be no placenta. Hæmorrhage ceased from the time I removed the ovum.

93. B——, æt. 49. Twelfth or fourteenth pregnancy; not above 2 months gone. On Thursday she had pain and some signs of miscarriage, which continued through Friday, but no loss till Saturday afternoon; and when it had continued above four hours, Mr. —— being all along present, I was called; found patient tossing about, faint, complaining also of sickness, from the considerable loss. Whilst Mr. —— persisted in giving brandy and water, I examined and found os uteri dilated enough to receive my finger (but no ovum protruding at os), so with my hand in the vagina, I got my finger into the uterus, detached the ovum by feeling all the inner surface of uterus, and was able to bring away nearly all the ovum. The fainting occurring was the reason for thus proceeding; otherwise, when the loss is well borne, we let the case go on till the ovum protrudes at os, and even then allow time for its expulsion into the vagina or outwardly, unless the degree of loss calls on us to remove the ovum now more accessible and easy of removal. Mrs. B. rallied, had no more loss, and did quite well.

94. ——, again miscarried. A sudden flow the first symptom; precautions immediately taken; but in two days ovum presented, and to prevent her powers being reduced by great loss, I with Mr. —— agreed to detach the ovum, which I did by inserting my finger in utero, and at length brought the ovum away, or rather the placenta, for the fœtus had passed away the day before. She did well.

95. Coe, æt. 28. Fifth pregnancy; 6 months; without

known cause, except that there was hæmorrhage, and one may suspect the partial separation of placenta some days before, but it was not over the os uteri. Has only once or twice gone her full time.

96. Giles, æt. 27. Fourth pregnancy; three former terminated in miscarriages from 4 to 5½ months; this was at 6 months. Child dead, and seemed to have been dead a day or two. Mother in perfect health.

97. N——, æt. 39. Seventh pregnancy; three miscarriages with hæmorrhage since last regular labour. Taken with influenza whilst epidemic and died of it. She went on for 19 days very bad with cough and raising, and when her pulse had been 150 for a day or two, labour at 6 months came on. She died in three days more.

98. W——, æt. 28. Fourth pregnancy; three months. This lady was disposed to consumption; two or three of her infants had died of jaundice soon after birth. The relaxed state of system doubtless disposed to miscarriage.

99. Coe, æt. 32. Eleventh pregnancy; 6 months. Mother relaxed and suffering much loss previously.

100. H——, æt. 37. Seventh pregnancy; 6½ months. Child alive and vigorous; weighed 4 lbs.—This infant weighed,

at the end of the 1st week	.....	4lbs.	2 oz.
In 3 weeks	.....	5	12
5	.....	6	8
6	.....	7	6
7*	.....	7	10
8	.....	8	9

* During this week he was not well.

PART II.

THIS part of the work comprises a number of cases attended by Mr. Crosse, in consultation; together with remarks on some of the principal subjects to which they refer. For facility of reference, I have adopted the following arrangement of the Cases, purposely omitting those of *Inversio Uteri*, this being the subject of a special Essay by Mr. Crosse himself, now in course of publication in the Transactions of the Provincial Association.*

ARRANGEMENT OF CONSULTATION CASES.

1. Diseases of soft parts complicating Labour.
   Ulcer on the Os Uteri.—Malignant Tumour.—Closed Vagina.—Tumor Ovarian?
2. Displacement of soft parts complicating Labour.
   Hernia Vesicæ.—Prolapsus Uteri.—Prolapsus Recti.—Fæces in the Rectum.
3. Difficult Labour, requiring Vectis or Forceps.
4. Do. ——————— Turning.

* Two parts of this valuable Essay have already appeared in the Provincial Transactions, and it is much to be regretted that the talented Author of it was removed from his earthly sphere of usefulness before its completion. I have reason to think, however, that sufficient materials have been left to enable some other person, who may be willing to undertake it, to publish the third and last part, comprising the treatment of Inversio Uteri.

5. Difficult Labour, requiring Embryotomy.
6. Spontaneous Evolution.
7. Artificial premature Labour.
8. Placenta.
   Prævia—retained—adherent—"previous separation."
9. Injuries to soft parts.
   Laceration of Os Uteri.—Inversio.—Rupture of Uterus.—Sloughing of Vagina, &c.—Ruptured Perineum.
10. Concomitant diseases.
    Measles.—Swelled glands in the Throat.—Convulsions.—Hemiplegia.—Fracture.—Delirium.—Mania.—Cramp.
11. Diseases occurring in consequence of Labour.
    Flooding.—Syncope.—Hysteritis.—Puerperal Fever.—Peritonitis.——Diffuse cellular inflammation in Pelvis.—Fever.—Phlebitis.—Phlegmasia dolens.
12. Diseases of Infants, including injuries.
    Eruption and inflamed Breast.—Congenital Tumor.—Sore from the use of the Vectis.—Dropsy and contracted Ileum.

CHAPTER I.

DISEASES OF SOFT PARTS COMPLICATING LABOUR.

Case 1.—Ulcer on the Os Uteri.

Mrs. ——, under 40 years of age, and mother of several children, applied to me May 1st, 1827, with symptoms of disease of uterus, indicated by pain, and foul dark stinking discharge. Soon afterwards I examined, and found an ulcer at the os uteri. After this examination, she followed my advice, and had no intercourse with her husband; her health was in a few weeks reduced by this painful disease, and she took to her bed. In August, the abdomen was found increased in size; she was emaciated and haggard from suffering and discharge. About the end of August, she had a loss of two or three pints of coagulated blood, per vaginam; and on the 3rd September, I was summoned, and found she had voided a fœtus, and I removed the half-putrefying placenta, which I found partly without the os uteri. The curious part of the case is, that with such a disease of the uterus, and so much pain as she complained of at the time of connection, she should have conceived—and the fœtus must be four months old, because she has been solitary all that time. She was hurried the night after this unexpected change—had a rigor—pulse 160—and died on the 6th December.—No examination allowed.

Case 2.—Malignant Tumor of the Uterus.

The most extraordinary and anomalous case which I have hitherto met with in the whole course of my practice is the following:—Some of the circumstances appear so monstrous, that credit would not be given to the narrator, except by those to

whom he was known by the station he held, or the correct statements he had offered to the public on other subjects. Yet were I to publish this case, I could scarcely refer by name to other parties—fellow-witnesses of the dissection—for delicate reasons that must occur to every one. I was called up at two o'clock this morning by Mr. ——, to go to H——, a distance of seven miles, to a case of midwifery, attended with some unaccountable circumstances; and though the woman was dead, the three surgeons who had been with her, wished me to go for their satisfaction, as they did not like to quit the house, leaving the woman undelivered, unless they could explain what had happened; and they moreover wished to inspect the body, which they feared would not be allowed if they once quitted the house.

The history I learned was, that this woman, near 40 years of age, had borne six or seven children; the last labour happened near two years ago, which was natural. She thought herself again pregnant, and near her full time. A month ago or more, she had been blooded on account of pain on the right side of the body. She was a feeble woman, and these symptoms were then attributed by Mr. H—— to the ordinary circumstances of pregnancy. She also became somewhat jaundiced, and continued so. She complained of labour pain, as it was supposed, at noon yesterday (Saturday). Mr. H——, who had been engaged to attend, was sent for in the afternoon—he was from home, but arrived at five o'clock; and on examining, though there was very slight pain, he found a soft tumor in the vagina, reaching nearly to the external labia, which he supposed was the liq. amnii. distending the membranes. Soon after, Mr. —— (who had been sent for on its being found that Mr. H—— was from home) arrived, and on examining, thought the placenta was at the os uteri. At seven o'clock, they left the patient for two hours, during which time she slept a little, and had not much pain. On returning and again examining, they believed the placenta was presenting, and that it was a case for turning. Mr. H—— ruptured the presenting part, or the part low in the vagina, expecting the waters to escape, but only a little blood flowed; he brought away several portions of solid substance, not unlike the placenta after being well washed in water. Some of these portions were bigger than a hen's egg, and were

shewn to me on my arrival. Having acted thus far under the impression that the case was a placental presentation, the same belief was entertained by both gentlemen present; and whatever was the position of the child (at one time the breech, at another the occiput, was thought to be felt), they believed turning would be the proceeding; so Mr. H—— having removed his coat and bared his arm, introduced it through the mass in the vagina; and believing he must reach the uterus, could not explain why he did not distinctly feel the child, but thought at one time he got the foot of the child; he however could not retain it; he got hold of something else, and no doubt used some force with the hand; but throughout the whole of this history I am unable to give a statement of what force was employed; it must be inferred from the subsequent part of the case. On withdrawing his hand, he brought away a firm whitish substance, which appeared like a bean. Mr. H——s likened it to a bile-stone—it was soft enough to be powdered readily. Mr. H——s next introduced his hand, but could not detect a fœtus; he however felt the spine—said he could feel a bag of such stones as the one brought away by his more active and more experienced companion; neither of them, however, suspected that the hand had been introduced anywhere but into the uterus. Numerous portions of the whitish soft mass, resembling by candle-light well washed placenta, were brought away. The woman died half an hour after these attempts, though there had not been much loss of blood; a gradual loss, but no rapid flooding.

Owing to the inexplicable state of the case, Mr. —— had been sent for, I believe before the woman died; but she was dead before he arrived; probably the patient died between 10 and 11 o'clock. It was to meet these three gentlemen, and for the reason stated in the beginning, that I was summoned, and I arrived at half-past three in the morning, three or four hours after the patient had expired.

The corpse was lying on the bed, on her left side, doubled up in the usual position for examining during labour, with her clothes on; and the quantity of coagulated blood on the bed, reaching down to the feet, shewed there had been no inconsiderable hæmorrhage. I introduced my hand into the vagina, felt lacerated parts, but could not distinguish fœtus or os uteri. My coat being

on, I could not proceed far with the hand, and I did not wish it, preferring to leave the parts for internal inspection just as they were. On withdrawing my hand, portions of a substance, twice as big as a walnut, escaped, of precisely the same appearance and soft consistence as what had been removed during life. Enough of this mass, in detached pieces, was shewn me, to fill perhaps a pint mug. Placing the corpse on the back, I made an incision in the course of the linea alba into the abdomen, extending from sternum to pubes; and as soon as the peritoneal cavity was opened, I discovered a quantity of coagulated blood, as much as 8 or 10 oz., spread on a thin layer over the intestines. The uterus immediately presented itself—it contained an acephalous fœtus, plump and full grown in its limbs and body, and apparently not less than eight months old. The placenta was cut through in making a longitudinal incision into the uterus, answering to the linea alba, for it (placenta) adhered to the anterior and upper part of the uterus—the membranes were entire—only an ounce or two of liquor amnii in them—the os uteri open to the extent of a shilling, but it had never been dilated nor meddled with in all the examinations which had taken place during the supposed labour; for the uterus lay high above the pubes and forwards, pressing immediately behind the anterior parietes of the abdomen. Pulling aside the uterus, and also the intestines, so as to examine the cavity of the pelvis, I found the whole of this cavity occupied by a morbid mass of tumor, soft and elastic to the touch, altogether in bulk sufficient to fill two quart mugs—some tumors were bigger than the largest orange, others the size of a walnut, all united together with serous or peritoneal membrane. Through the most compact of this morbid mass, in the centre of the pelvis, anterior to the rectum, was a lacerated opening leading into the vagina; and it was clear the hand of the accoucheur had made its way through this passage into the peritoneal cavity. One inexplicable circumstance during life was now explained—the gall bladder was ruptured at its larger end—several small whitish biliary calculi were amongst the viscera near it—numerous others were in its cavity, one big as a nut, occupying the cystic duct—others varying in size from a pea to a bean; altogether I collected 56 of these calculi—not including two or three removed per vaginam during life. The liver was of a slate

colour by candle light, and particularly soft in its structure, so as to be easily torn with the fingers—kidneys and bladder healthy, as well as the surfaces of the peritoneum ; but upon the spine, behind the mesentery, by the side of the aorta, there were large morbid masses, precisely like the tumor in the pelvis—soft—brainular. I took out the uterus and the morbid parts. On strict examination, and unravelling as it were the latter, I found that the great mass of these tumours had originated in the right ovarium ; one single tumor of the same structure occupied the left ovarium. Examined by day-light, the tumors and uterus had a yellowish or sallow tinge from jaundice—the tumors were so soft that when the external peritoneal covering was broken through, the finger passed easily through the mass in any direction. The chest was not examined, for unavoidable reasons ; but it was not necessary to go further, no doubt being admissible as to the malignant and constitutional nature of the disease ; and all the peculiarities of this rare case being those referring to the connection between the pregnancy, the disease of ovaria, and the treatment to which erroneously and unfortunately it led.

* The facts I deem to be made out are, that malignant tumors, forming in the right ovarium chiefly, medulary sarcoma or soft cancer in nature, growing rapidly as they are known to do, probably in this case having made all their progress since the preceding labour two years ago—a form of disease in females most often found in the breast or ovarium—I say these tumors in the right ovarium attained a large growth, filled the pelvis—descended into the vagina, carrying I presume the lining of the vagina before them—the tumours thus impacted in the pelvis and vagina would be pressed and fixed by the gravid uterus. Such was their position and such the circumstances when labour was supposed to be indicated by pain and forcing down ; though I doubt, and Mr. H——s expressed to me that he now doubts, whether any real labour or contraction of the uterus to accomplish expulsion of a mature fœtus took place. However, it was supposed to be labour —the mass in the vagina was mistaken for placenta presenting—the loss of blood was not so great as to make active measures urgent, even under this impression—but in examining, force enough was used with the finger to break through the membrane of the vagina ; the hand entered one of these soft tumors ; and,

being pushed on in the idea of searching for the fœtus to turn it, readily broke through the peritoneal covering of the tumors, and was free in the cavity of the abdomen. In searching for the limbs of the child (monstrous as the narration must sound in the ears of every practitioner who hears it), the gall bladder, which contained numerous gall stones, was grasped and pulled at with sufficient force to rupture its coats—a calculus or two escaped—one was seized by the fingers of the accoucheur, and from the peritoneal cavity brought through the lacerated opening of the tumor, and through the vagina, so as to be examined externally. All this time, the uterus remained untouched—the os uteri was over the pubes—the hand passed just anterior to the rectum and near the prominent lumbar vertebra. The curved posture of the patient, with knees drawn up to the sternum, pressed down the liver and gall bladder. A second gentleman introduced his hand into the peritoneal cavity, so as to feel the bag of bile stones and the liver, as he assured me afterwards. No wonder the woman should die shortly after such mischief was effected.

The melancholy reflections in this case are, that there was probably no uterine or true labour pain at all; that the patient would not at present have died without the unjustifiable interference of the accoucheur; that had nothing been done, but patient waiting been tried, labour might have come on at a future time, and the nature of the case been unveiled, the os uteri felt, the tumors been recognised to be such hanging into the vagina, and pressed back, allowing the fœtus to descend*—that under the impression of the placenta being at the os uteri, more deliberate investigation was not more gently made, and, in doubt, no active means adopted, for there was no flooding urging the immediate proceeding for delivery.

The palliating circumstances must be sought for in the rarity of the case, for which no ordinary practitioner can be quite prepared. When once the hand was in the abdominal cavity, and

* Mr. Bailey, when at Sudbury, was called by several practitioners to a case they could not understand, but had been deliberating about, rupturing an elastic bag presenting in the vagina—he recognised a tumor, which he advised them to endeavour to push up—this was done—the uterus descended—labour went on—a child was born regularly and safely, leaving the patient to contend (with what final result I know not), with the tumor in the pelvis.

supposed to be in the uterus, the violence used in seizing a gall bladder, supposing it some part of a fœtus, will not appear so astonishing. The consolatory reflections to those who, open to errors as others, are desirous of doing their duty humanely and to the best of their powers (and such I believe to be the desire of Mr. H——, the less active person in the tragedy, although it was his patient)—the consolatory reflections are, that the disease was malignant, and must ere long have destroyed the woman—that the fœtus was a monster and could not have lived—that it is doubtful, with such a mass occupying the pelvis and filling the vagina, whether during labour, any attempts to press up and keep aside the tumors, would have allowed the fœtus to descend or to be brought down and labour effected without at once sacrificing the life of the mother.

Case 3.—Impervious Vagina.

Mrs. L——, æt. 21—married near four years—this her first pregnancy, and arrived at about the full term. Labour pains began at ten on the morning of April 16, 1840. Mr. W—— was called at 4 p. m. and at 6 sent for me on account of the peculiarity which will now be explained. I found labour so far advanced that the child's head was near the perineum, and could be felt through a thin membrane, there being an occlusion of the labia which the parents had never discovered—this perhaps prevented her being pregnant sooner, but of course there was a small opening in the membrane through which pregnancy was effected. I introduced a director into this opening, and carrying it towards the rectum, found no difficulty in there perforating the membrane with the director, and dividing it in its whole extent with a sharp curved bistoury. Thus I got the finger into the vagina, and in contact with the cranium of the child. I then left the case to Mr. W——'s care, not doubting but labour would go on regularly to a speedy termination—4½ hours after I left, a boy was born, healthy and right, in the usual course.

April 23.—All has gone on favourably.

Case 4.—Tumor in the Pelvis.

Mrs. B——, mother of a large family, and whom I was called to on account of a tedious labour, and used the forceps.

The child then born was dead; she has once miscarried since.—She had been 12 hours in labour under the superintendence of Mr. R——; gone her full period—was very large in the body—aged 44 years. I arrived at 6 p. m., Nov. 6, 1829. Pains not very severe. On examining, I felt a large mass very low in the vagina, filling the pelvis—could not feel os uteri; but on pressing on this mass, could feel what seemed like the limbs of a child felt through the soft parts half an inch in thickness. On examining this presenting mass strictly, and carrying the finger as high up as the highest part of the very prominent sacrum, I could feel no os uteri, closed or open. I thought of extra-uterine fœtus, or ovarian tumor. I determined to examine deeper, and removing my coat and baring my left arm, I carried my hand above the brim of the pelvis, past the presenting tumor, until it had cleared the projecting sacrum; and when the arm had been introduced nearly to the elbow, I felt the os uteri fully dilated, thin membranes presenting, through which I could feel the head and hands of a full-grown fœtus. Now I so far understood the case as to know that a tumor, connected probably with ovarium, filled the pelvis, having its attachment by a broad basis to the anterior wall or pubic direction of the passage, allowing the hand to pass behind it, close upon the very projecting sacrum and lowest lumbar vertebra. Whilst my hand was thus deeply immersed, a pain came on—the membranes broke, and a great portion of liq. amnii escaped. Before more should escape, since turning must obviously be practised, I determined to proceed in this measure, and succeeded in bringing down both feet, and after a few pains the fœtus was brought away living. I removed the placenta soon afterwards, and twice introduced my hand to examine the tumor which had created so much difficulty and obscurity—found it big as to require my two hands to cover it; fixed by a broad basis anteriorly—yielding on its surface, but having hard masses within it. I had thought that if the tumor were pendulous by a narrow neck, it would be desirable to bring it down through the vagina and leave it thus, that it might at a future time be removed—but a re-examination shewed me that the tumor was fixed by a broad basis, and could not be brought down lower. The uterus, when contracting during after-pains, was felt, after delivery, as high nearly as the navel, as if there had been another child; but I

had ascertained that it was empty, and was convinced that it was kept so high up by the tumor, which I presume was ovarian. I left the patient an hour after delivery as well as after a common labour.

Nov. 25.—I learnt this patient had done quite well.

Case 5.—Tumors in the Abdomen, &c.

Mrs. D——, aged about 30. Repeatedly in the last several years has she, whilst single, suffered attacks of constipated bowels. In the first attack to which I was called there was pain, tenderness, fulness of one ovarial region; and I thought inflammation and suppuration occurred: which opinion was borne out by the result, for pus was discharged by the bowel—the constipation was relieved—all tumor and tenderness subsided, and the patient went about in comfort. On another occasion, when called in consultation, I found great constipation for weeks—induration—enlargement in right ovarial region—also in other parts of the abdomen. Dr. —— was called in after me, and I understood that by croton oil, free glystering, &c., he unloaded the bowels—the patient, long confined to bed, and regarded as being in an almost hopeless condition, rallied and got about; and it passed for a case of accumulated fæces in the colon, &c. Soon after this, the lady married, and after a time became pregnant. She was seven months gone in pregnancy when I was called in on account of stoppage, vomiting, great pain coming and going like muscular pain. I examined per vaginam, and could feel the head of the fœtus through the uterus. There was one large tumor, big as a child's head, just below the liver—another in the abdomen as large as a fœtus's body; and the fœtus in utero occupied the usual situation. By glysters largely given, the patient obtained some relief; and late in November, Mr. S—— attended on her for 24 hours or thereabouts, during a tedious labour; and after a full-grown fœtus was born (a boy, which took an hour to revive), I was called on account of retention of the placenta—this however was removed an hour after the delivery of the child. I was informed that during labour, on Mr. —— first examining, he found a soft tumor presenting, but could feel no os uteri—under severe uterine pain and strong expulsive effort, something was heard to give way with an audible noise, and there was a

large discharge of matter. Mr. S——, on then examining, found that the tumor was gone, and felt the os uteri—then labour went on regularly, but slowly. After labour was over, there were in the abdomen the two tumors as above stated, besides the uterus, and I knew not what to make of the case.*

Remarks.

It perhaps does not frequently happen that impregnation takes place during the existence of ulceration at the mouth or neck of the uterus, but Case 1 proves the possibility of such an occurrence; and La Motte relates a case in which there was reason to believe that cancerous ulceration of the os uteri had existed during several pregnancies, complicating labour with flooding, which seemed not to depend upon the usual causes. Two months after the patient's last delivery, the speculum discovered the os internum hard, uneven, and very sensitive; entirely occupied by an ulcerated cancer, full of hard knobs, which furnished a discharge whose smell was intolerable.†

It is exceedingly important to the accoucheur to bear in mind the occasional though not frequent existence of tumors seated in the pelvis, that he may be prepared to combat the difficulties which they usually give rise to during parturition. Sometimes these tumors are bony, in the form of exostosis of the sacrum, or of pointed projections from ossification after fracture of the acetabulum. Sometimes tumors are found growing to the sacro-sciatic ligaments, obstructing the outlet of the pelvis; or there may be fibrous tumors of the uterus, accumulations of water in cysts, cartilaginous or glandular swellings, or, what are much more frequent than

* This lady recovered her usual state of health after her confinement, left Norwich some years ago, and is at present residing in a distant county.—Ed.

† La Motte's Treatise, by Tomkyns. 1746. P. 508.

any of the rest, various kinds of enlargement of the ovaries. Case 2 also proves the possibility of malignant brainular tumor being so situated as to create difficulty in parturition, and points out most forcibly the importance, the vital importance, of the practitioner being acquainted with the possibility of the occurrence, and exercising caution in the management of so grievous a calamity.

The following case of removal of a large pelvic tumor by Dr. John Burns, is very interesting, particularly as illustrating the treatment required in such circumstances:

"In a dreadful case which I met with, the attachments were extensive, and the tumor so large as to fill the pelvis, and permit only one finger to be passed between it at the right side of the basin. It adhered from the symphisis pubis round to the sacrum, being attached to the urethra, obturator muscle, and rectum; intimately adhering to the brim of the pelvis, and even overlapping it a little towards the left acetabulum—it was hard, somewhat irregular, and scarcely moveable. The patient was in the ninth month of pregnancy—there was no choice except between the Cæsarian operation, and the extirpation of the tumor. The latter was agreed on, and I performed it on the 16th of March, a few hours after slight labour pains had come on. An incision was made on the left side of the orifice of the vagina, perineum and anus, through the skin, cellular substance, and transversalis perinei. The levator ani being freely exposed, the tumor was then touched easily with the finger; a catheter was introduced into the urethra, and the tumor separated from its attachments to that part. It was next separated from the uterus, vagina, and rectum, partly by the scalpel, partly by the finger. I could then grasp it as a child's head, but it was quite fixed to the pelvis—an incision was made into it with a knife as near the pelvis as possible; but from the difficulty of acting safely with that instrument, the scissors, guided with the finger, were employed when I came near the back part; and instead of going quite through, I stopped when near the posterior surface, lest I should wound the rectum, or a large vessel, and completed the operation with a spatula.

The tumor was then removed, and its base or attachment to the bones, dissected off as closely as possible. Little blood was lost—the pains immediately became strong, and before she was laid down in bed they were very pressing. In four hours she was delivered of a still-born child, above the average size. Peritoneal inflammation, with considerable constitutional irritation, succeeded ; but by the prompt and active use of the lancet and purgatives, the danger was soon over, and the recovery went on well. In May, the wound was healed. On examining per vaginam, the vagina was felt adhering, as it ought to do, to the pelvis, rectum, &c. The side of the pelvis was smooth ; and a person, ignorant of the previous history of the case, or who did not see the external cicatrix, could not have discovered that any operation had been performed. After a lapse of more than 15 years, she still continues well, but has never been again pregnant."*

The following recapitulation of the *treatment* of pelvic tumors is concise, practical, and in accordance with the best opinions upon the subject. It is given by Dr. Blundell, in his Principles and Practice of Obstetricy, and I make no apology for inserting it :—

" The principal practices, admissible in these cases of pelvic tumors, concurrent with parturition, are the following : the urging of the tumor above the brim of the pelvis, if indeed this can be done with gentleness ; the giving a few trials to the natural efforts ; and the reduction of the bulk of the intumescence by puncture or incision. Other practices, not to be forgotten, where the former fail us, are embryotomy, embryotomy in conjunction with the puncture of the tumor, applying the forceps, turning, the Cæsarian operation, and extirpation of the tumor, either by abdominal or vaginal incision. Extirpation of the tumor, by way of the vagina, may, perhaps, in an improved state of abdominal surgery, prove of valuable use ; but till facts have accumulated, it is better to refrain. On reviewing the cases† which have

* Principles of Midwifery, by J. Burns. Ed. 8, p. 34.

† " One case I know of, in which the tumor was pushed above the brim of the pelvis, both the mother and child recovered.

" Four cases I know of, in which the tumor was laid open by puncture or

been subjected to those different practices, we may, I think, safely conclude, that unless the tumor can be urged above the brim, to open it is the most desirable practice, unless, indeed, it can be wholly extirpated."* "When you do operate (by incision), recollect that a fold of intestine may lie in the way."†

incision; in the first of these, the mother recovered with difficulty; in the second, imperfectly; in the 3rd and 4th cases, she died; in one of the cases about six months after the operation; three of the four children were saved; of eight lives, therefore, five were preserved, and three were lost.

"Eight cases have come to my knowledge, in which embryotomy was adopted; in these cases, two of the mothers recovered, one of them imperfectly, and five of them died; of course all the children were lost; of seventeen lives, therefore, three only were preserved, and fourteen were lost, for one was a case of twins.

"Of puncture and perforation combined, that is puncture of the tumor, and perforation of the head, three cases are known to me; in one, the mother recovered; in the second, she died; in the third, she sank 18 months after the operation; all the children were lost; of six lives, one only was preserved.

"Of turning, I have five recorded cases; in four of them the mothers died; in all, the children; of ten lives, therefore, one only was preserved, and nine were lost." *Dr. Blundell.*

* Page 668.

† Le caractère de la plupart de ces tumeurs est facile à saisir; mais il en a quelques-unes qu'on pourrait confondre avec d'autres sur lesquelles il serait dangereux de porter l'instrument tranchant; comme avec ces hernies entéro-vaginales décrites par *Garengeot*, et les hernies de vessie dont parlent plusieurs auteurs. On distingue aisément l'abcès qui est la suite d'une tumeur inflammatoire, d'un dépôt froid; parceque les signes commémoratifs n'en sont pas les mêmes: mais l'on ne reconnoît souvent la nature de ce dernier qu'après l'avoir ouvert. C'est cette espèce a qu'on quelquefois peine à distinguer des hernies dont nous avons parlé, et plus difficilement encore de certaines tumeurs sanguines qui ont leur siège profondément dans le tissu cellulaire du vagin : ce qui doit rendre tres-circonspect pour les ouvrir quand elles mettent de grands obstacles à l'accouchement. —*L'Art des Accouchemens. Par J. L. Baudelocque.* Vol. 2, p. 261.

CHAPTER II.

DISPLACEMENT OF SOFT PARTS COMPLICATING LABOUR.

Case 6.—Hernia Vesicæ.

Mrs. S—— has had three children—she has a hernia vesicæ, the bladder turning back from the pubes, and its fundus, covered by vagina, presenting at the labia externa. During labour the bladder descends, and if full of water, presents first on examination and might be mistaken for the membranes distended with the liq. amnii—but if the urine be drawn off, this tumor subsides and the os uteri is felt.

Case 7.—Inversion and Protrusion of the Bladder through an opening into the Vagina.

Mrs. C——, æt. 29. Ten years ago her first labour occurred, and instruments were required to effect delivery. After this labour, which was protracted several days, the patient never retained her urine, it always dribbled away. Three years after, her second labour took place, under similar but less difficult circumstances. Her third labour occurred in the present May, and is the subject of the following history. She was about seven months gone—the nurse arrived at 7 a.m., when the membranes had already ruptured spontaneously, and at 9 a.m., a dead fœtus was born. Nurse waited an hour and a half, and then sent for a surgeon, on account of the placenta not coming away, and her not feeling it, but something irregular, on examining. Mr. R—— came, broke the cord, but did not get the placenta—two other surgeons were called by him, but could not explain the case. At 3 p.m.

Mr. —— saw the case, and at 6 p. m. requested me to meet him. We found a swelling, the size of a very large pear, prolapsing so as to be visible between the labia, and the hand passing, it could reach the os uteri, which the finger entered. The nature of the tumour I could not explain, though I did conjecture it was what it afterwards proved to be. The patient's condition was very bad—rapid small pulse—tender abdomen—anxious countenance. There was no reason to suppose ruptured uterus—and the practice seemed clear, to soothe by anodynes, to support the patient by bland food, and to leave the placenta to come away ot itself. Next morning (Thursday), the placenta was expelled by the spontaneous action of the uterus; but the patient shewed signs of peritoneal inflammation—body tumid and very tender. She died on the Friday. The next Monday morning, at 6 a.m., I attended the dissection. The shape of the abdomen was convex and very prominent—abundant lymph and serum in the peritoneal cavity from general inflammation of the peritoneum. The uterus was healthy in size and every other appearance except its peritoneal covering. Just behind the pubes and anterior to the neck of the uterus, it seemed the peritoneum had been injured, if not torn through; which happened no doubt within a few hours after the expulsion of the child, from rough usage to ascertain the nature of the presenting tumor, and to remove the retained placenta. The prolapsed tumor was the bladder itself inverted through the large opening into the vagina, formed by sloughing after the first labour—consequently the lining membrane of the bladder was the covering of the tumor presented to our view between the labia; and it was found that the ureters opened upon the surface of the prolapsed tumor. I cannot help suspecting that the peritoneal inflammation was the result of violence done to the patient in rude attempts to investigate the nature of the case, and to gain and remove the placenta.

Case 8.—Rectum loaded with Fæces.

Sept. 13th, 1820. I was called to Mrs. B——, a midwife having been with her for 36 hours. The rectum was loaded with fæces, and was by my direction freed by a glyster; in seven hours she was delivered without instruments. She had had six children before, and generally good times.

Case 9 —Prolapsus Recti.

Connected with this subject, I introduce a notice of the case of a lady, aged just above 40—mother of many children, and had a large family quickly. She came to me on account of a tumor prolapsing between the labia, so as to be visible ; which I found to be the anterior part of the rectum descending through the vagina ; it returned when she was recumbent.

Case 10.—Calculus and Prolapsus Uteri.

A single woman was pregnant, and while in that condition the uterus prolapsed and was returned. She afterwards voided a calculus *per urethram*, gained entire ease, and went to the full term of pregnancy. It may be asserted that the increased weight of the uterus, during the early months of pregnancy, is a predisposing cause of prolapsus—a calculus in the bladder is also a predisposing cause.

Remarks.

In the 7th volume of the "Memoires de l'Académie Royale de Medicine," Paris, page 486, will be found a very useful paper on the subject of prolapsus of the rectum into the vagina, and through the vulva *(rectocèle vaginal)*, by J. F. Malgaigne. He appears to have been the first to give a clear description of the nature of this disease, and to distinguish it from simple prolapsus of the posterior wall of the vagina, and from prolapsus of the vagina consequent upon that of the uterus, both of which may occur without necessarily producing hernia of the rectum. Of 13 females in whom he noted the time at which *rectocèle* made its appearance,

4 were from 22 to 30 years of age.
4 ——— 31 to 40 ———
4 ——— 41 to 50 ———
1 ——— 53 ———

Of these, all but one had borne children before the accident, viz. :—

3 had had	1 child.	
2 ———	2 children.	
2 ———	3 ———	
2 ———	4 ———	
1 ———	6 ———	
1 ———	7 ———	
1 ———	10 ———	

In 14 cases, the causes to which the affection was referred were as follows :—

In 4 who were not pregnant, the cause was a fall, a blow, or violent efforts.

3 were advanced from 6 to 9 months in pregnancy ; in two of these the rectocele had come on without any other cause than pregnancy.

6 had it as a consequence of labour.

1 in consequence of an abortion.

In a total of 16 cases, the rectocele was simple or complicated in the following proportions :—

Simple rectocele	5
Rectocele complicated with cystocele	7
Rectocele complicated with prolapsus uteri	1
Rectocele with cystocele and prolapsus of the uterus together	3

The tumor itself varies in size, from a simple fold, which scarcely extends beyond the orifice of the vagina, to that of an egg, or even the fist. The diagnosis is extremely easy. If the patient be directed to make an effort, a tumor of more or less size will be found dilating the posterior part of the vulva, and increasing in size according as the effort is greater or longer sustained.— The finger introduced into the vagina ascertains that the tumor belongs to the posterior wall of this canal, and that the uterus remains in its proper place.

The affections capable of being mistaken for rectocele would be prolapsus of the mucous membrane of the vagina, an abscess formed behind this membrane, an intestinal hernia which had passed between the vagina and rectum, or a cyst in the same situation.

But an unequivocal pathognomic sign is derived from the introduction of the finger into the rectum; by which it is found that the vaginal projection answers to a pouch in the intestine; the finger being curved reaches the summit of the tumor projecting through the vulva, which happens in no other case.

The disease is attended with obstinate constipation, with spasmodic constriction of the sphincter ani, during attempts at stool, and various distressing affections of the digestive organs.

The treatment recommended by M. Malgaigne consists in clearing away the fæcal matter contained within the tumor by means of repeated injections of warm water, and applying a hollow caoutchouc pessary of a particular shape, to support the protruded parts, and retain them in their natural situation.

With respect to *calculi in the bladder*, Dr. Blundell* remarks, that they are not unlikely to obstruct delivery, and ought to be taken away before, if their existence has been ascertained. If the stone be large and have remained undiscovered in the bladder till parturition begins, it would, he says, be advisable, if practicable, to urge the stone above the brim of the pelvis, so as not to interfere with the passage of the child; but if it obstructed delivery, and could not be got rid of in this way, it would become necessary to remove the calculus by operation.

Burns† also observes, that a large stone in the bladder may be so situated during labour, as to diminish very much the cavity of the pelvis; and it may be even necessary to extract the stone before the child be delivered, if it have not been pushed above the brim in proper time.

* Page 663. † Principles of Midwifery, p. 33.

CHAPTER III.

DIFFICULT LABOUR REQUIRING VECTIS OR FORCEPS.

In the following 25 Cases, the vectis was used twice successfully, and the forceps in the remaining 23; in two of the latter, the vectis had been tried and failed, before the forceps were employed. Seven of the children were still-born, and three died shortly after birth. The mothers all recovered.

Case 11.

Mrs. G——, 5th child. Labour being tedious and of 12 hours' duration, the midwife sent for me. The child was large and the pelvis narrow; but labour might in time have been finished by the natural powers—however, feeling an ear, I used the vectis, and, without injury to mother or child, finished in a few pains what might have required several hours of exertion.

Case 12.

Mrs. S——, æt. 22; first pregnancy. The midwife had been with her above 40 hours—natural presentation, but slow pains. I found the head just entering a narrow pelvis—uterus open—waters away—could not feel an ear by any effort—tried the vectis, but could not act enough with it—waited two hours, when I applied the forceps without having been able to feel an ear—in half an hour a living male child was born.

Case 13.

Mrs. A——, æt. 28; first pregnancy. A midwife had been with her 28 hours—yet, with powerful pains, the head had not much advanced. I could feel an ear, and the difficulty seemed to arise from the pelvis being narrow, with a considerable projection of the highest part of the sacrum. I applied the forceps, after some delay and some difficulty—but it required all the force I had to use, for many returning pains, before the child was extricated. Although the child had been felt to move a few hours before, it was still-born and could not be revived.

Case 14.

Mrs. ——, æt. 24; first pregnancy. Mr. —— called me after she had been 16 hours in labour—we waited 12 hours more, when I applied the forceps, the head being favourably placed, and the presentation natural. She might have done without the forceps, but her sufferings had been long and severe, the pains began to be irregular and to abate; a large living boy was born, and to the large size of the head the difficulty must have been owing, rather than to a pelvis smaller than common. The child was born with two pains after the forceps were applied, and the mother did well.

Case 15.

Mrs. C——, æt. 38; first pregnancy. The os uteri dilated very slowly; I had to draw off the water after 18 hours' labour, and in doing it, found difficulty in introducing the small catheter until I had laid the patient on her back, and pushed the head up firmly. When the os uteri was dilated, I tried the vectis, but could not act with it. I felt an ear; and after the head had not advanced for many hours, I used forceps, and soon delivered.—The introduction of the forceps caused cramp in each thigh. The funis and heart of the child were beating, but no breathing; and inflating the lungs and immersion in water did not revive it, the heart gradually, and carotid arteries also, ceasing to beat, and death ensuing. This child was living, and no doubt well, at the beginning of labour; and I wish to know how far the use of instruments enfeebled it, and how far the protraction of the labour. Next day I had to draw off the water, after which it flowed re-

gularly. Stools from castor oil on the 3rd day—on the 4th, the pulse 120, and great pain in the thigh, but body free from pain.

CASE 16.

K——, æt. 45. At her first labour the child's head was opened—the three subsequent ones were lingering, but terminated naturally. She is small and badly made. At her present labour, the pains had existed many hours before I was sent for. I found the os uteri fully dilated at seven in the evening (August 3rd), and the membranes presenting, but no head to be felt. For five hours the tense membranes presented, and I could feel no head; but incessant strong pains continuing, the membranes at last ruptured. I am convinced they were so tense as to retard the labour, and that I ought to have ruptured them before. The head after this descended, and a hand presented with it towards the sacrum. I pushed the hand up, prevented its descending during a pain, and thus got rid of it, the head advancing slowly for some hours with very strong and rapid pains. At one o'clock the head had descended so as to be very near the perineum; but after that, it was stationary for two hours, when I went home for catheter and instruments, not a drop of water having been passed for eight hours, during which I had cleared the rectum by repeated injections. After I returned, she had a pain or two, but they then entirely and suddenly ceased, the patient complaining of distressing pain about the navel, wondering what could have happened to her, and stating it to be worse than all her labour pains—the breathing became hurried—the skin cold and covered with perspiration—vomiting. I introduced the catheter, and drew off not above 3 oz. of bloody urine; and this led me to suppose the bladder might be ruptured, as, during the eight hours, tea and cold water had been frequently drunk to the amount at least of two or three pints; making it extraordinary and incredible that only so small a quantity of urine had been passed. During the eight hours, she had had no inclination to make water. No pains returned for two hours—she remained cold and clammy—pulse small and 130. I then applied the forceps—one ear of the child was to the pubes—I brought the head out pretty readily, but there was not the least uterine contraction. The placenta separated and came away with the child, which was still-born.

August 4th. I drew off a quarter of a pint of water at 9 a.m., and larger quantities at noon and evening. The woman got warm, but pulse 130.

5th. Pulse the same—water drawn off three times in tolerable quantity—no discharge from uterus. Abdomen tumid and elevated, tender on pressure. I applied leeches, and afterwards a blister. Pil. Cal. Jal. taken in the evening.

6th. Water twice evacuated—senna and salts procured stools —urine twice drawn off—pulse in the evening only 100—no uterine discharge. After this she did well; the lochial discharge taking place and the urine being properly evacuated.

Case 17.

Mr. R—— called me to a patient who had been in labour 12 hours—I found the head low so that I felt an ear, and used the vectis with speedy effect—a living, full grown fœtus. In three former labours the children died, two being only seven and one an eight months' fœtus. The additional difficulty in this case was attributed to her going her full time.

Case 18.

Mrs. H——, æt. 28. First child—had been 18 hours in labour, the head for the last six hours resting on the perineum, when Mr. W—— called me to her. Finding the perineum sufficiently yielding, and the pains so dull as to promise a continuance of her present situation for many hours, I readily applied the forceps, and in four pains the child was born lively and vigorous. The use of the forceps might have been avoided, as the labour would have terminated well without them, the patient being cool and not over-exhausted—but I knew I could apply them readily; and several hours of pain and suspense were thus avoided.

Case 19.

Mrs. G——. Delicate, sallow, always feeble and complaining—had slight pains during the whole of Wednesday, June 14—which increased at midnight so much that the waters broke, the child descended, and in the yielding state of the parts, it was expected a few pains would effect the purpose; when all pain ceased, and for two hours scarcely returned. I was called—found

child's face to the pubes; and after waiting some time without any effectual, though occasional very slight pains, I applied forceps and in two pains the child, a boy, was born; but I could not revive it, though I tried three-quarters of an hour. This was delay from feebleness of frame and want of pains, the mal-position of the head just creating more difficulty than the uterine action could surmount.

Case 20.

On 7th July, I applied forceps in the case of Mrs. R——; seventh pregnancy. Os uteri dilated fully for ten hours—very hot weather—patient talked incoherently—being much heated and feverish. On examining I felt the left eye, and the left ear was near the symphisis pubis. I applied Assalini's forceps—thought I could, as the head descended, turn the face to sacrum; but allowed it to incline which way it would, and the position became face exactly to the pubes. In former labours she had tedious times, the head resting at the brim of the pelvis, till the os uteri was fully dilated; but forceps were never required till now, when a full-sized child having face to pubes rendered their use necessary. The child was still-born, but revived from proper means and did well.

Case 21.

Mrs. W——, æt. 30. I attended her in her first labour, and used the forceps after 48 hours, a projecting sacrum narrowing the capacity of the pelvis. In her second pregnancy a midwife attended, and delivery took place in two days without instruments. In the third, the midwife called in a surgeon after long waiting, who delivered by forceps. These three children are living.—On account of the fourth labour I now write. A midwife ruptured the membranes at the early part of the labour—when labour had continued 30 hours, a surgeon was called, who tried to deliver by forceps, but could not succeed. The forceps slipped, and he tried to change the position of the head with one blade. I was summoned, found the head very high, but could feel an ear next the pubes—I succeeded in putting on the short forceps, and in half an hour the child was born—the head passed the projecting part of the sacrum with a jerk—i. e. as soon as it was

freed from the resistance of the projecting sacrum, it came with a sudden jerk, under the force I was applying, into the more spacious part of the pelvis. One of the parietal bones was so depressed, as to show a hollow like a small cup—child born alive, but died in four days. The woman had sloughs, a good deal of foul discharge coming away, and was in a dangerous state a week after delivery. She ultimately recovered.

This case would have done better if left more to itself—the midwife should not have ruptured the membranes—the surgeon would have been justified in waiting when he was called; but as he had used instruments, and that forcibly, I thought I ought to go on, because the parts would swell, and be more painful afterwards, interrupting the progress of labour, and making instruments absolutely requisite in the end, when they would be applied with more pain and much less chance of success.

Case 22.

Mrs. L——, æt. 38, a baker's wife. Five years ago I was called to her in her second labour, and we opened the head of a fœtus—since then, besides one miscarriage, she has had two children born living at the full term, without artificial aid. These children were rather small, and the presentations natural. On the 31st December, 1838, I was called in by Mr. ——, after Mrs. L—— had been 24 hours in rather strong labour. The head lay at the brim of the pelvis—os uteri amply dilated, and the external parts quite relaxed. Introducing my whole left hand into the vagina next the hollow of the sacrum, I could carry it up so as to feel the child's left ear; but I could not feel the right ear, the head lying so close upon the os pubis. The anterior lip of the os uteri was also enormously swelled. Mr. —— had seen the patient, but was not there when I arrived. Mr. —— was ready to perforate the head, but willingly embraced my proposal to try a long pair of forceps; so I used Naegle's long curved forceps, and got them well applied; and in half an hour the head was born—there was no pulsation in the funis, and we had no doubt the fœtus, a fine boy, had been dead some hours. The placenta shortly followed; the patient recovered. This was decidedly a case of narrow pelvis giving rise to the difficulty.

Case 23.

Mrs. D——, æt. 43; eleventh labour. Mr. —— called me in the evening, after the os uteri had been 14 hours dilated, and waters off. I could not feel an ear—child's face to pubes—the patient had a rapid pulse, was a large florid fat woman, and the pains returned very slowly, there being great exhaustion. I applied the forceps, used moderate force, and the child was born in 15 or 20 minutes. It required three-quarters of an hour's attention to revive the child, and bring it to an active secure state of breathing. The child died next day—the mother recovered.

Case 24.

Mrs. B——, æt. 40; fourth pregnancy—seven months gone. The waters broke and escaped daily for three or four days—then slight labour pains, under which the os uteri dilated, and the child's head descended—but suddenly the pains entirely ceased and did not recur. After several hours, I was sent for by Mr. ——; but as there was no hæmorrhage, nor other symptom to urge delivery, I advised delay. Ergot was thrice given, but did not induce contraction. I thought the pains ceased from the patient not having her expected attendant—the head lay very low, with an ear to the pubes, and the forceps could be readily applied: but I thought that if we delivered when no pain was present, there might be subsequent hæmorrhage from want of uterine contraction. For 24 hours there was little or no pain—an opiate at night had procured several hours of sleep. Now, on examining, after a few slight pains, a hand was found down—this was pushed back, the forceps were applied, and a living fœtus of between six and seven months was delivered in a few minutes. Both mother and child did well.

Case 25.

Mrs. C——, æt. 35; first pregnancy—full term—had been ten hours in strong labour when I was called—I found soft parts relaxed and well lubricated—head upon the perineum, and projecting between the external labia—still little or no advancement for three or four hours. Mr. —— called me, wishing to apply forceps—I deemed the rigid state of the os coccygis in so aged a primiparous patient the cause of delay. An ear could be easily

felt; Mr. —— applied the forceps, and in three or four pains a living fine girl was born. The placenta separated favourably.

Here the forceps safely expedited a delivery, which would, I believe, with a little more time, have been effected by the natural powers.

Case 26.

Mr. —— summoned me at ten o'clock this morning to the following case:—Mrs. ——, æt. 29. First pregnancy—full term. Labour pains began on Friday afternoon the 8th, and were slight during the night. Mr. —— was with the patient repeatedly on the 9th, indicating that some pains continued, and he remained with her all the night until I met him, when he informed me that at midnight, on account of pains diminishing, and os uteri not opening nor head descending, he gave gr. v. of ergot, which he repeated at four and again at six this morning, each time with temporary increase of the pains. The membranes had broken spontaneously at two o'clock this morning. An hour and half before I arrived, Mr. —— had tried the vectis without success, and afterwards applied the forceps; but with considerable force, he could make no progress in bringing down the head—I found the forceps still remaining, but not rightly applied, as he supposed. I felt an ear next the symphisis pubis (Mr. —— had not been able to feel an ear, and acted without this guide), and as the forceps answered to the transverse diameter of the pelvis, it was clear that one blade must be over the face and the other over the occiput. I removed the forceps, and applied them correctly. Pains went on, and with patient gentle use of forceps (for the pains were so strong and forcing, that I felt it right, at this stage of labour, and in a first case, to use very little force), the child was delivered—it was dead, as I knew it would be; for Mr. —— found the funis down two or three hours before I arrived, and it accompanied the head of the child, a fine female infant, which it was known had been living at the early period of labour—indeed, there is no doubt that the descent of the funis caused the death of the child. The impression I received was, that this case had been mismanaged—ergot, admissible where there is dull uterine action in relaxed parts, which a few good expulsive pains might terminate, was unsuited to such a first case, the head being high

up, the os uteri little dilated, and labour terminable only by long continued and oft repeated pains. Moreover, the forceps were too soon had recourse to, I believe, to say nothing of their erroneous application. Had ergot not been used—less consequence assigned to the pains—more time given—it might, I believe, have taken the course of a natural labour.

But the most important part of the case remains. The patient had taken a little warm beer to rally her, after so long and laborious exertions, and half an hour elapsed after the birth of the child when uterine contraction came on—the placenta descended so as to be felt in the vagina; and with the hand, I brought it past the os externum; but although nine-tenths of the placenta were thus visible, a portion remained adherent to a mass still occupying the vagina, as if another placenta were there—this portion of placenta still adherent was not healthy; for a fatty mass, the size of my finger, was visible, proceeding from the exposed portion of the placenta to the mass in the vagina. Was this mass the inverted uterus brought down? I think it could not be that only, and the morbid structure alluded to proves this. I took the course of not doing too much—I dared not attempt to remove the mass in the vagina; so I gently separated the placenta, by breaking through it level with the external labia, in which there was no difficulty, as the texture was soft—then by introducing my hand into the uterus, I carried up from the vagina into the uterus the mass described. I feel convinced there was morbid adhesion of placenta—morbid structure uniting placenta and uterus. I am not sure that the uterus was not inverted; but if it were, I replaced it. During all this time, there was loss of blood, and the patient became pallid and faint, requiring stimulus. I left her, entertaining the worst prospect—learnt that she was somewhat rallied after two or three hours; and in the evening she was satisfactorily improved, the pulse going well, no loss nor fainting. She recovered, although her abdomen enlarged and was tympanitic.

Case 27.

Mrs. K—— had a very severe labour in 1838. Since her labour in 1838 she was delivered as a Lying-in Charity patient. The midwife could not succeed, and Mr. —— was called, who

proceeded to deliver by turning; and when he had delivered the body, the head being still in the vagina, he left, although the midwife protested—she could not deliver the child, and twice sent for Mr. ——, who at length came and delivered; the child dead. On account of the treatment she thus received, I was requested to attend her in this labour (1841) which, through the influence of some ladies, I consented to do. I was called at five in the morning, and at eleven delivered by forceps—the face towards pubes—a living child, arrived, I think, not quite to the full term. Soon after this, a pain came; and then an immense flow of liquor indicated that a fresh cavity of membranes had broken, and that there was another child. I did not wait till the uterus was firmly contracted, but proceeded to deliver by turning, as the nates and not the head presented. I soon got a foot, and without great delay, effected the delivery of a male child, which was still-born; but I revived it, and soon it was as living as its sister. I found a projecting upper part of sacrum, narrowing the pelvis, and accounting for the difficulty. The woman did well, and the children also—she was a short woman, with short os humeri, and so far of a rickety aspect. The deformity of the pelvis has increased with her years, for by her first husband she had living children; but by her present husband, in five or six years, of four pregnancies no child had been born alive until now.

Case 28.

Mrs. C——, æt. 30; sixth labour. In three out of five former labours, the forceps were used, owing to the child's head resting on the pubes, and not descending. This time, after the uterus was dilated, no progress was made in several hours, and I used the forceps. The face was next the symph. pubis—a large living healthy child born, and all did well.

Case 29.

Mrs. H——, æt. 22; first pregnancy—in labour 24 hours. Mr. ——, who was in attendance, thought the forceps were required, but did not succeed in applying them, so he sent for me. I found an ear to the pubes, and the head low down—I readily applied the forceps, the first being placed over the ear I felt; and delivery was effected in 10 or 12 pains, with powerful traction of

the forceps—child living. I really here cannot say there was great difficulty; the soft parts and os uteri too were well relaxed —perhaps the pelvis was not well shaped, otherwise the ear should not have been towards the pubes, with the head of the fœtus so low upon the perineum.

Case 30.

Mrs. D——, æt. 23; first pregnancy—full term—had been in labour 24 hours—and for five or six hours the uterus fully open and head low—for several hours pains have nearly ceased—ergot given without effect. Mr. —— and Mr. —— were with the patient, and called me in—pulse quick—head low in pelvis, but perineum not very yielding—no urine voided for 16 hours, so I drew it off with a small flexible catheter. I applied the forceps—expulsive efforts were induced by this, and the head, with slight traction, pressed hard on the perineum—the latter, though supported, slit up, but I hope not to the sphincter ani—still on examination by the hand, I was convinced of its being torn—besides the bleeding indicated it.* The forceps came off the head, which was now so low, but there were again no pains; so I applied the forceps again, and with a single pain the head was born. The funis did not pulsate, and the child was still-born; no doubt it had been dead some hours—the placenta quickly followed the child.

Case 31.

I was called by Mr. —— to Mrs. P——, æt. 26; first pregnancy—labour going on for 26 hours, and waters escaped about 20 hours—I found the pains slow and feeble—os uteri well open —soft parts yielding—anterior fontanelle presenting, and face to pubes—head of child very yielding and compressible. The malposition of the head is here the cause of difficulty in a tolerably formed pelvis. The forceps were readily applied by Mr. ——, and he for a little, and I afterwards, acted with them until the head rested on the perineum; the rest was effected by natural pains—child living and well—the placenta did not separate for one hour.

* Mr. —— next day told me this patient was doing well, and that he examined the perineum before he quitted the room, and *it was not torn*—still my impression is very strong to the contrary.

Case 32.

Mr. —— called me to Mrs. ——, 38 years of age; first child—labour had been going on all day, and at 10 p. m., on first examining, I found os uteri fully dilated—still I advised delay till morning; and then being again called, and finding scarcely any change after nine hours, I applied forceps, and succeeded without great effort—the child was living, but died an hour after we left—the woman recovered.

Case 33.

Nov. 19, 1843. ———, æt. 22; first pregnancy. Mr. —— had been 11 hours with the patient when he called me, stating that she had slight curvature of the spine—head had not advanced for four hours, although the pains were good and frequent, and he thought the pelvis narrow. My opinion really was, that with more time the case would progress; but the parts were relaxed, and I assented to give aid. With the vectis I brought the head down to the perineum, then left it to the pains for some time—still, as progress was slow, and soft parts well relaxed for a first labour, I applied forceps and safely effected the delivery of a fine female living child. In some measure the forceps were used out of complaisance to a worn-out timid medical man; and as I could do it safely to the patient, I assented; but I did not consider that the necessity for using instruments was clearly made out. The woman recovered favourably.

Case 34.

Mrs. L——. In first pregnancy there was a very tedious labour, owing to a narrow pelvis. In the second I used the forceps. In the third, being the present case, the head could not be felt, even when labour pains had gone on for hours, and were very strong. The membranes broke, and still I could only just feel the head at the brim of the pelvis; but with violent pains, the head descended somewhat in an hour or two. Still I could not feel an ear, even when I introduced the whole hand into the vagina. The patient being most clamorous, I attempted to apply common short forceps, but could not succeed; so I left, to be out of the way for a time, and meaning to return provided with longer forceps and vectis—but on reaching the patient after an

hour's absence, I found the child just born and living; proving there was neither need nor the least propriety in the use of instruments for delivering the patient.

Case 35.

A woman, æt. 22; first labour; had been 30 hours in labour; for 12 of them, in severe strong pain. When Mr. C—— called me in, the pains were severe and frequent; the head low, so that I could feel an ear—I was told it had been so placed 10 or 12 hours; and as the soft parts were sufficiently yielding to allow of the forceps being, as I thought, safely used, I applied them, and in half an hour, delivered a living female child of good size.—The placenta was removed in 10 or 15 minutes. This was a right presentation, and the difficulty arose solely from too great resistance from a rather narrow pelvis. The patient recovered favourably.

Remarks on the use of Instruments.
(by Mr. Crosse).

The use of Instruments to hasten labour may be sufficiently discouraged in books, and the cases in which they are strictly required clearly pointed out in lectures; but amongst the circle of Practitioners of Midwifery under my own observation, I have the means of knowing that there are many who indiscriminately employ them against all rule, reason, or propriety—I refer more particularly to the vectis; with which I am told delivery is easily expedited without any injury to the mother. This may be generally stated with truth by those who, always armed with this weapon of offence, employ it on every occasion that they approach the bedside of a female, when the child happens not to be born before their arrival; because a good pelvis, relaxed parts, and an advanced position of the child's head (the state of things in a great majority of patients at the time the accoucheur

is sent for), enable him to effect delivery with a single pain, and so little force, as shall leave all parties safe and uninjured. But such, however, are not the circumstances that call for the employment of the vectis, though I believe it is better fitted to these cases than to any other, having in many instances of real difficulty seen it attempted to be used and relinquished for the forceps, which never disappoint the experienced man. But whoever uses the vectis on these occasions will not fail to try it when there is some difficulty to overcome.

I commenced practice with a most formidable notion of the difficulties and responsibility of practising midwifery, and a lively apprehension of the danger and immorality of employing instruments unnecessarily. After some experience, in which I have carefully studied to steer a middle course between the indiscriminate use of instruments and too great a reluctance to employ them, I am come to the conclusion that I have used them more frequently than I ought to have done.

The act of parturition is a painful, a most unaccountably painful process; and to lessen the suffering by shortening its duration (instruments never lessen it in any other way than by shortening it, as they invariably increase the degree of suffering at the moment), must be the anxious wish of every humane mind. But let those who are forward to interfere with the regular efforts of nature, be sure that they are not considering their own personal convenience, instead of acting from feelings of humanity, and under the guidance of sound experience and good reasoning. I can readily believe that if the vectis be used when the pelvis is large, the maternal parts relaxed, and the fœtus properly placed, it may at once complete delivery, which would be delayed many hours, from the pains being slight and occurring at dis-

tant intervals; and that mother and child may be uninjured (except that both must suffer some pain from the means employed): and even where some difficulty has to be overcome, the experienced in the use of the vectis may succeed without injury to the mother; but the fœtus, whose sense of touch is fully developed, though it has no means of expressing pain but by a movement of its limbs, suffers whenever either the vectis or forceps is used, and is brought into the world exhausted, still, or lifeless, requiring great care for its revival. I wish those who are forward to use the vectis, and who argue that it does no injury, inflicts no suffering upon the child, would sleep with an iron night-cap once in a week, and tell us what sort of repose they get. Let the advocates for the use of instruments, vectis or forceps, to expedite labour that might be naturally terminated without them, ask themselves what are the effects of a vectis or end of a spoon used as a scoop, to remove fæces from the rectum; and how they would like to have such an instrument employed to expedite the delivery of a costive motion?—The bowel here resembles the uterus—the natural process of delivery is very much the same—there is a mucous sensible lining membrane—a sphincter muscle to dilate and to act upon—muscular coats of the bowel itself to propel and expel the contents—and how painfully do the use of instruments affect these living textures! So is it in the case of a labour treated by instruments merely to expedite what might be accomplished by the natural efforts. But the aggravation of this case is that the instrument presses upon, injures, pains, a living, sensible, substance—the child—which suffers even more than the mother; whilst in the other case, the substance to be delivered is insensible, inanimate. This comparison is sufficiently just, and puts in its proper disgusting and inhuman light,

the practice of certain accoucheurs of employing instruments upon every occasion where labour is a little delayed, so as to give them the opportunity. Happy for the patient, whom such practitioners are engaged to attend, if a circumstance, that needlessly alarms her and all around, happen, viz. the child being born before the accoucheur arrives.

I lately heard that Mr. ——, of ——, used forceps in a case rudely—did such injury that a bowel escaped per vaginam—and on dissection *post mortem*, the exact mischief was ascertained by other surgeons, who hushed up the business.

Mr. ——, of ——, in a natural labour, which had not lasted above six or eight hours, rashly used the forceps. The patient died of flooding, after the birth of the child, before another practitioner could be got to the spot. The operator soon after quitted his practice for a distant residence.

To sum up, in a few words, my opinion of the vectis, it is equally dangerous and inefficacious—dangerous to both mother and child—inefficacious to terminate labour, unless used in cases of such slight difficulty as, by the consent of all reasonable, honest, and judicious men, ought to be left to the efforts of natural pains, and the patient's own instinctive efforts for their happy completion.

Additional Observations on the use of Instruments (by the Editor).

The observations which Mr. Crosse has offered on the use of Instruments generally in the practice of Midwifery, must meet with the consent and approbation of all feeling men; by some they may be considered too severe and indiscriminate against the employment of in-

strumental aid; but it must be remembered, they are directed chiefly against the *abuse* of instruments, and particularly against the employment of them as a means of suiting the personal convenience of the accoucheur. Mr. Crosse has recorded cases which prove him to have been an adept in the use of the forceps, and in which it cannot be denied that, however great his dislike to instruments, he could have succeeded by no other means equally safe to mother and child; and in reflecting upon the history of the art of Midwifery from early ages to the present time, we cannot but be struck with the important advantages which have been derived from the timely employment of artificial assistance, and the great saving of life both to mothers and children, thus effected since the discovery of the forceps and vectis. It rarely happens, however, that useful discoveries are unmixed benefits; like every thing else they are liable to abuse; and such has been the case, whether from ignorance, boldness, or impatience, with the instruments used in midwifery.

Mr. Crosse prefers the forceps; says, "they never disappoint the experienced man," and although he gives no separate directions as to the manner of applying them, the cases afford some instruction upon that point, and ample directions are given in all good systems of midwifery. It will be seen also, that although Mr. Crosse had frequently employed the vectis in his early practice, he now discards it as a useless instrument, "equally dangerous and inefficacious." The testimony of Denman, on the other hand, is equally strong in favour of the vectis; he states, that he never knew a practitioner relinquish the vectis for the forceps, but that he has known the vectis successful where the forceps have failed. Such are the contradictory opinions with regard to the com-

parative merits of the two instruments; and it seems to me that the real difference consists more in the skill of the operator in the use of his favourite instrument, than in the superiority of one instrument over another. It must be allowed, however, that, amongst writers of the present day on the art of Midwifery, the forceps are almost universally and exclusively recommended; and I scarcely know of a good description of the proper form and mode of employment of the vectis. It is nevertheless the instrument I always use, and this I believe to be the case with many other practitioners. As a student I was taught to prefer the forceps, and commenced practice with a prejudice in their favour; but the gentleman with whom I entered into partnership had, during his whole professional life, employed the vectis, and that only; and I found it absolutely necessary to my success in midwifery to use it also. That Mr. —— used it occasionally when not necessary, I have not the slightest doubt; but many of his patients were so importunate for the assistance it afforded them in his hands, that I was, as it were, absolutely obliged sometimes to follow his example. The consequence has been that I have acquired a certain confidence in the use of the vectis; and it has been effectual for every emergency in head presentation which has occurred in about 1500 cases, with two exceptions, where there was deformity of the pelvis, so as to create a necessity for craniotomy. A single blade of forceps bears but little analogy to a properly formed vectis, although it has been frequently used in its stead. A vectis should be much more curved near its extremity than a blade of the forceps, and it then forms a *tractor*, possessed of considerable power, and capable of overcoming no slight degree of difficulty.

In the above number of cases I have never witnessed

the death of a mother, when the vectis has been employed, nor severe inflammation, nor sloughing of soft parts; and although several children have been marked more or less, the injuries sustained have not been great, and very soon recovered from. It is scarcely probable but that there must have been cases amongst the number above quoted, which would have demanded the use of forceps, if the vectis had not been employed; and it is impossible for greater success to have been obtained. Although, therefore, I am perfectly free to confess that Mr. Crosse's observations are extremely just, and worthy of attention, as to the use of instruments generally, my own experience contravenes my assent to his views as to the inutility and inefficiency of the vectis; and, to use his own words, on this point "we agree to differ."

In conclusion I would observe that, with respect to the comparative value of the two instruments, according to the freedom and dexterity with which the practitioner can employ either, so will he recommend that particular one to the notice of the profession; and that, with certain restrictions as to shape and size, the skill of the operator is of more consequence than the description of instrument he employs. The vectis, however, labours under this disadvantage, namely, that as it is more easy of introduction, so it is more liable to abuse by too frequent application; yet, skill in the use of any instrument cannot be obtained *without practice*; and cases will *sometimes* occur where the possession of such skill is of vital importance. Whilst, therefore, it is incumbent upon us to qualify ourselves for emergencies, let us at the same time never cease to remember that our best judgment and kindest feelings should be exerted to the utmost to discover in *how many* cases instruments may be avoided,

and *how few* there are in which they are imperatively demanded.

Since writing the above, I have removed from the country to Norwich, and been appointed Consulting Accoucheur to the Lying-in Charity of that town; and the result of my consultation practice, with reference to the employment of the vectis in difficult labour, has confirmed my previously favourable opinion of the efficiency of the instrument.

On the evening of March 4th, 1848, Mr. —— sent for me to assist him in the delivery of Mrs. P., æt. 34, in labour with her first child. Mr. —— had been in attendance from 7 a. m., and had tried both vectis and forceps without success—the head was in the natural position, but wedged in at the inlet of the pelvis, which was very small. I applied the vectis with some difficulty, and in less than an hour succeeded in delivering her of a dead female child. I found the left wall of the vagina torn and ragged; the left parietal bone of the infant had a very deep depression, apparently caused by the promontory of the sacrum, and there was an enormous *caput succedaneum*. The vectis was applied to the right side of the head, and slightly marked the temple. The woman had a good recovery.

On the 27th January, 1849, I was requested to go with Mr. —— to a case of labour, the patient being an unmarried female, 27 years of age, who had suffered from spasmodic movements similar to chorea for ten days previously. The labour pains were spasmodic and distressing, and the os uteri very slow to dilate. As soon as a pain came on, so as to exert any pressure on the cervix uteri, she was thrown into convulsions, and the progress of labour interrupted. After this had gone on many hours, and the general condition of the patient had become somewhat alarming on account of great weakness and irritability, Mr. —— requested me to deliver with the vectis if I thought it *practicable*, and expressed his doubt as to any other means being effectual.—

Chloroform was administered for the purpose of lessening the convulsive attacks, with partial success ; and *as soon as the os uteri was opened sufficiently to admit fairly the blade of the vectis,* I applied it and quickly effected delivery. The child was born alive, and the woman ultimately recovered.—In this case it is clear the forceps could not have been applied without injury to the partially dilated uterus. Indeed, I do not see how the two blades could have been introduced at all, with the head so high and the uterus so little dilated ; such was also the opinion of the gentleman attending with me, who was himself well practised in the use of the forceps.

On the 15th of March, 1849, I was called to a patient, 35 years of age, in labour with her first child. The head was well into the pelvis, but was there impacted for many hours, and the efforts of the surgeon in attendance to deliver with the vectis had failed. In consequence, he requested my aid, and I succeeded with my vectis in soon bringing into the world a fine living female child. The mother recovered.

On the 18th of October, 1849, I met Mr. —— in consultation in the case of Mrs. B——, in labour at the full period—fifth pregnancy. In her first labour she had a small living child, delivered by forceps. In her second, craniotomy was performed ; as also in her third. In the fourth, she was delivered, by turning, of a still-born child. In the present case, she had been in labour a great many hours, and it was clear both that the child could not be born alive, and that her general condition forbad further delay. We agreed, therefore, to open the head ; but there was afterwards so much difficulty in getting it into the world by the usual means, crotchet, blunt hook, &c., that I proposed using the vectis for the purpose, and succeeded with very little trouble or delay. I had in other cases found it a good instrument with which to complete delivery after perforation of the head.

On the night of the 27th of March, 1850, I was requested by a surgeon to accompany him to the house of a poor woman in the city, in labour with her sixth child. A midwife had been in attendance 13 hours before calling in any assistance, and stated

the head had been engaged in the pelvis during chief of that time; the surgeon had been in attendance eight hours before I went, having tried the forceps for a long time without success.—When I arrived, she was in a state of extreme collapse, and had for hours before complained of severe pain in the "stomach," which she called cramp. There were restlessness, vomiting, imperceptible pulse, cold surface—indeed such depression and exhaustion that I felt sure she had no chance of recovery.—The question of perforation was proposed, but I requested a trial with the vectis, and with little delay succeeded in effecting delivery. The child was dead, and the mother lingered two days; never having regained her pulse, and dying of universal peritonitis, the early stage of which had passed into that of collapse previously to her being delivered.

Summoned to Mrs. K——, a few miles into the country, in labour with her 12th child. She has a small pelvis, and has always had difficult instrumental labours. Mr. —— had been in attendance many hours, and after attempts with both vectis and forceps, requested my assistance on the morning of June 9th, 1850. The head was so firmly impacted that I had some difficulty in applying the vectis, but in about half an hour delivered her of a fine living child. Both mother and child did well.

June 20, 1850. Summoned to a lady, 30 years of age, in labour with her first child. Child's head large, with a tendency to come down face towards pubes. Patient very stout, pelvis small, perineum very thick and powerful. Mr. ——, a gentleman of much experience in midwifery, had been in attendance many hours, and sent for me at 6 a. m., on account of severity of labour without progress; it was determined to attempt delivery with the forceps, and Mr. —— applied them well, but after giving them a full trial, did not succeed. Before entertaining the question of perforation, he acceded to my trying the vectis, and after a short time I was fortunately enabled to deliver the patient of a fine living male child, whose head was slightly marked with the instruments, and *very much elongated.* Both did well, the mother recovering without a single untoward symptom. The gentleman with whom I attended, afterwards expressed to the friends

and to myself, his belief, that no other mechanical means could have succeeded, with safety to the child, in this particular case.

Mr. —— requested my aid in a case of first labour, on the 19th July, 1850. The woman had been in pain a good many hours, the uterus had been fully dilated for some time, but the head, although well into the pelvis, made no progress, even with good strong and regular pains. Both vectis and forceps had been tried before I arrived, and the vagina was becoming dry and hot. I applied the vectis, and quickly delivered her of a living child. The mother had a good recovery.

The cases just quoted must tend to convey a favourable impression of the vectis, when properly shaped and handled. My object is not to make a comparison between the merits of the vectis and forceps, but simply to defend it as a useful instrument in many cases of Midwifery. In my own hands, the vectis is incomparably the better instrument, for it has so constantly answered my purpose, that I have had no occasion to resort to the forceps, and am therefore not at all familiar with them; my impression is that I can deliver any case with the vectis that I could with the forceps, and many that I could not; and since I have been fortunate enough to succeed with the vectis in several cases where others, skilled in the management of the forceps have failed with them, I have been necessarily led to the conclusion that it is an instrument too useful to be entirely neglected in the art of Midwifery.

CHAPTER IV.

DIFFICULT LABOUR, REQUIRING TURNING.

Case 36.

Aug. 8, 1821. I went to Plumstead, at 3 a. m., to a patient of Mr. B——, whose case was as follows :—Age 32, ruddy, full, and strong. In first pregnancy, the labour was premature, an arm presented, and Mr. B—— turned readily. In this her second case, there were pains rather trifling for 15 hours, without os uteri dilating. At eight o'clock last evening, pains powerful ; at ten the uterus dilated, an arm presenting. Mr. B—— broke the membranes—he tried to turn, but found such violent pains, so contracted a uterus, and feet so high, that he gave it up and waited till I arrived. I found an arm projecting, and shoulder wedged in the pelvis. My hand with much difficulty passed anterior to the spine, till it was covered up to my elbow, before I felt a knee (child's abdomen lying to mother's spine). A foot I could scarcely have reached ; nor could I bring a knee down, except by using a hook. Strong and frequent pains. After bringing down one foot and tying tape on it, I wished, as the pelvis was bad and sacrum projecting, to get the other foot ; but I found so much difficulty that I gave it up, and by regular pulling during a pain, I brought the child round with the one leg, and it was delivered in about an hour from my first entering the room, the head taking many pains to bring it through the vagina. I knew the child must be dead.

Case 37.

A middle aged woman, of tough fibre. In first pregnancy labour came on at seven months, an arm presented ; she did well.

Mr. S—— attended at her second labour, which also came on at seven months—the funis presented—the membranes ruptured of themselves, descending quite to the os externum. The umbilicus of child was presenting, and as the os uteri was open, Mr. S—— and Mr. K—— tried to get the hand into the uterus, but could not succeed in feeling a foot, great resistance being afforded by the violent action of muscles of the perineum. I was called—my left hand passed the vagina—the umbilical region of the child was presenting—I felt a hand, and the chest of the child was next the bladder. Against the spine I found a foot, and got it low enough to put a ligature on it. Mr. S—— then delivered the child, which had probably been some hours dead from compression of the funis—it was under seven months. The afterbirth followed soon after the delivery of the fœtus. The woman continued to do well for a week, when fever and some symptoms of inflammation came on requiring active treatment.

Case 38.

Mrs. B——, æt. 36, has had six labours before, with regular times. In the seventh case two midwives were present when I was called ; eight hours before, the waters had ruptured and the funis descended. I found the funis hanging out, and a hand and shoulder to be felt. After descent of funis for so many hours, I entertained no doubt of the child being dead. The necessity for turning was obvious ; and the os uteri being open, I turned with the difficulty usually experienced when the waters have escaped and the uterus is contracted. The placenta separated readily, and I left the woman doing well.

Case 39.

A woman, in her third labour—arms presented. The surgeon in attendance was unable to turn in the contracted uterus, and sent for me, when I readily accomplished it. Child dead—woman recovered.

Case 40.

Mrs. R——, æt. 30. In first pregnancy Mr. B—— opened the child's head owing to projecting sacrum, narrowing the pelvis in that direction. In the second, she bore a living child. Her

third labour was the occasion of the following tragical history :—April 10th, 1842, when she was arrived at the full period of gestation. The preceding night she took two opening pills, which acted at seven this morning ; and in another hour she was again out of bed on the commode for copious alvine evacuation. Whilst up on this second occasion, she was sick and vomited ; and was faint, so that she nearly fell down, and remained some time before she could be replaced in bed. From this period she complained of pain in the bowels, and a strong feeling as if motion was required to be passed, although there was no further evacuation. Mr. B—— was with the patient at half-past eleven a. m. still pain in the bowels ; complained of a degree of faintness—tenesmus—but on examining per vaginam, Mr. B—— states he found os uteri not dilated, and finding labour not going on, left the house. At half-past 12 he was again with the patient, and now the os was considerably dilated ; the patient complaining of pain as before, and desire to have a motion—also very faint, and cold on the surface ; so much so that Mr. B—— gave diluted brandy, and applied bottles of hot water to the feet. As labour pains went on quickly, and os uteri was dilated, he ruptured the membranes. Before this, only a very small coloured loss had taken place. Labour pains went on, and the child's head descended ; but great faintness continued, and when I arrived, a quarter before two, the patient was just sensible, but bloodless, cold, and without perceptible pulse, although as much brandy had been given as she could swallow. Mr. B—— supposed that the uterus was ruptured ; but no fœtus could be felt in the abdominal cavity —the head of the child had not retired ; and besides, the patient had not vomited since eight in the morning, and the fluid was pale, not like coffee grounds, as I believe is invariably the case in rupture of the uterus. Again, uterine pains had gone on, which, in a uterus extensively ruptured, would cease, and no expelling power, I should think, be felt. I thought, therefore, that there was not a rupture of the uterus, but intra-uterine hæmorrhage from partial separation of placenta preceding labour, and which it seemed to me probably had arisen during the commotion and exertion from the active purging caused by the pills, and whilst the patient was on the commode. Immediate delivery seemed to be the only course—to relieve the mother if there was

any chance of that—and still more to afford a chance of saving the child. The head was not low enough for forceps to be used—as the patient was still breathing though scarcely sensible, ventro-section was inadmissible—so whilst brandy was still put into her mouth with a tea-spoon, we proceeded to turn, and with no great delay, a full-grown male fœtus was delivered, still-born, and we could not revive it. The mother expired before delivery was effected. The afterbirth was immediately brought away, and several pints, perhaps five or six, of coagulated blood followed, leaving no doubt of intra-uterine hæmorrhage, as I had suspected.

These are the worst of cases, even much worse, more appalling, than hæmorrhage from placenta prævia, which exhibits obvious symptoms to awaken the accoucheur's attention in time—whilst in intra-uterine hæmorrhage the mischief occurs insidiously, with no other sign than abdominal pain, faintness, and distress, but not developing at an early period symptoms for forming such a decided diagnosis as to warrant proceeding to effect delivery, which would be the only way to give a chance of safety; and for the want of such early and clear diagnosis, such cases always, it is to be feared, prove fatal.

Separation of the placenta leading to hæmorrhage, may be classed—1, before labour; 2, during labour; 3, after delivery of fœtus. The first is what I am now considering, and to which the preceding remarks and case apply. The blood at first lies between the uterus and membranes, these separating the blood from the liq. amnii—but the hæmorrhage being great, the membranes will be broken up and then blood mixes with the liq. amnii—hence these remarks may be made:—

1st.—There may be no outward hæmorrhage, although the os is dilated—even the liq. am. may escape little tinged, the blood being retained by the membranes, between them and the uterus, and the child's head descending low.

2.—The liq. am. may be tinged or mixed with blood, the membranes having been broken up from without inwards by increase of hæmorrhage.

3.—The blood extravasated between the membranes and ute-

rus, may be situated near the os uteri, and detaching the membranes, some may escape at the os uteri, although the membranes be still entire.

Remarks.

The operation of version or turning was more frequently performed many years ago than at present; formerly, it was adopted as a means of effecting delivery in many cases of head presentation, in which forceps or vectis are now employed; formerly also, it was usual to turn in cases of breech or footling presentation, the operation consisting of turning the head into its proper position; thus converting an unnatural presentation into a natural one. It was frequently a clumsy, difficult, and dangerous operation, and the occasion of much suffering and loss of life.

At the present day, turning is not at all, or very rarely, resorted to in head presentation, and never in breech or footling cases. It is however necessary in presentations of the upper extremities or body of the child, and is sometimes advisable in presentation of the funis; but the operation now consists, not in bringing the head down so as to be the presenting part, but one or both feet, converting the unfavourable presentation into a footling case, the head escaping last from the pelvis. When the os uteri is fully dilated, the soft parts relaxed, and the membranes not ruptured, it is by no means a difficult matter to turn; but when the liq. amnii has escaped, and the uterus has contracted forcibly upon its contents, the operation is more difficult; indeed it may, under such circumstances, be exceedingly difficult, perhaps impracticable; painful to the accoucheur; and dangerous to the mother, from the risk of ruptured uterus, or subsequent inflammation. In addition to the presentations of the

upper limbs, and different portions of the trunk, other circumstances may require the operation of turning, such as placental presentations, some cases of hæmorrhage from previous separation, of convulsions, &c.

As to the manner of performing it, some recommend the left hand, some the right; with some it is made a point of importance to gain both feet, whilst others think it better to draw down one foot only. The grand point is to effect it by *gentle* means, making use of no rapid or rough manipulations. The right hand is so often employed for examinations, that it is generally more cognizant of the position of the child; and owing to its greater acuteness in recognizing the parts with which it is brought into contact, it appears to me generally the best to employ for turning. Yet it must be allowed that the left hand can be passed into the uterus, with the knuckles corresponding to the hollow of the sacrum, in a less constrained position than the right; and it would probably be desirable for beginners to cultivate the sense of touch in the left hand as much as in the right. With respect to the other point above referred to, it is stated, and I should think with good reason, that when only one foot is brought down, the other forms a protection for the funis, preserving it from too much compression, and the child is more likely to be born alive. But on the other hand, when there is much obstruction to the passage of the child, and considerable extractive force is required, the child is more likely to be injured if pulled by one leg than by two; because, in the latter case, the force employed for its extraction is diffused over a larger portion of the body, and thus is more able to be borne.

When the lower extremities have been brought into the position of a footling case by turning, it is important to leave the expulsion of the child, as much as possible,

to natural efforts; because, by drawing down the body artificially without uterine pain, we run the risk of separating the chin from the breast of the child, and placing the head in a less favourable position for passing through the pelvis. It may, however, be necessary to deliver quickly, whether there be natural contractions or not, in which case this rule cannot always be observed.

These, however, are matters which, like many others in the practice of Midwifery, must, after all, be decided by the individual judgment and discretion of the practitioner at the time he is required to act; only let it be remembered, that whatever is to be done should be effected by gentleness, patience, and with a thorough knowledge of the object to be attained.

CHAPTER V.

DIFFICULT LABOUR, REQUIRING EMBRYOTOMY.

Case 41.

Mrs. K——, æt. 32. In her first pregnancy, there was severity as usual—in the second, instruments were required to effect delivery—the 3rd, 4th, and 5th labours terminated regularly under the attendance of a midwife, who in this, the 6th labour, had been in attendance nearly 24 hours before she called in medical men, who found the head high in the pelvis, and assisted with the vectis, and thus got the head fairly into the pelvis—afterwards a small pair of forceps were applied, but they slipped off, and would not act, so a larger pair were put on. With these, all the force which Mr. S—— and Mr. W—— could use, failed to accomplish delivery, and I was called. Finding that the labour had gone on for 26 hours, the forceps tightly applied for one or two hours, no movement of the fœtus felt since the beginning of labour, I was fully satisfied that the fœtus was already dead; so I would not make any further attempt with the forceps (though the head was near the external orifice), but had them removed, perforated the cranium, and in an hour effected delivery; using the bill-forceps more than the hook, and waiting for the return of slow pains.—This patient afterwards recovered without any unfavourable symptom.

Case 42.

Mrs. L——. On the 12th of March, 1840, I was called to her by Mr. S——, this being the third labour in which I had received a summons. The second was last year, when I delivered

her with the long forceps. In the present instance, full term of pregnancy, labour going on for 12 hours, the funis had descended for five or six hours, as soon as the os uteri was open, and Mr. S—— had tried to put it back, but in vain. When I arrived, there was no pulsation in the funis ; indeed there had been none for several hours, so that the child was certainly dead ; and as the head lay too high for delivery by forceps, and the uterus was contracted, the waters having sometime escaped, the obvious course seemed to be to perforate and diminish the size of the head ; this was done, and delivery accomplished. Next day the patient was doing most favourably.—I think Mr. S—— stated this to be the 6th time that artificial delivery had been effected.—I called six days afterwards, and all was right.

Case 43.

Mrs. H——, æt. 36 ; has had 10 or 12 pregnancies ; repeatedly slow labours ; and more than once the forceps had been applied. Once, the head not descending, delivery was effected by turning. I was called, after the patient had been 30 hours in labour ; indeed the waters had broken 30 hours before, and Mr. T—— remained from that time in attendance—he and Mr. G—— had in vain tried to apply the forceps before sending for me. I found the child's head so firmly impacted in the pelvis, that I could not get a finger between either pubes or sacrum and the head. I could not feel an ear, and could only insert the forceps at each lateral space—this I did, trying in succession two different pairs of short forceps—but though apparently well applied, they slipped off the head on extractive force being used, and this repeatedly. I observed that though I could apply them readily, it would be at random, without any certainty of each blade going over an ear.—The patient was worn down by long and severe pains, and we agreed to open the head, which Mr. G—— did ; and in 10 minutes from the insertion of the perforator, the child was delivered—it was a very large child—the forceps had left an indentation on the forehead, but came nearer the right position than I expected ; but the blade did not reach far enough, and I had to regret not having used Naegle's long forceps a little curved, as I think I might have succeeded, and given a chance of the child being born living.

CASE 44.

Sept. 15. Mrs. H——, æt. 38 years; 7th labour. In her 5th labour forceps were used, but the 6th proceeded naturally, though very tedious. Mr. B——, at eight last evening, found the os uteri dilated fully, and the waters had escaped suddenly in very great abundance. He gave ergot repeatedly in the night; and finding the head high and no progress made, he used vectis. Subsequently he applied Assalini's forceps, and with all the force he could allow himself to use, he could not bring the child's head down. The forceps were still applied when I arrived at 7 a. m. I made traction with them several times during pains, but with no effect. The forceps being removed, I found the head above the brim of the pelvis, bulging forwards over os pubis anteriorly; and posteriorly I could feel an ear opposite the lowest lumbar vertebra with the hand fully introduced into the vagina, the uppermost part of sacrum being very prominent, so that the antero-posterior diameter of the pelvis was very narrow. It was stated, that the child had been felt to move within a few hours. I saw no chance of delivering by forceps—indeed I could not have applied the forceps over the ears of the fœtus, and am sure Mr. B—— had not done so, but made each blade answer to the lateral aspect of the pelvis; so we agreed to perforate, and, this being done, two hours elapsed before delivery was completed, the cranium of the child being very firm—a very large fat female child. The patient recovered.

CASE 45.

Mrs. S——. In her first labour, the head of the child was perforated, and the child got away in an hour or two. In the second, the same was done, and in the course of a day the fœtus came away putrid. She is under 30 years of age, and I was called on the 25th of July to meet Mr. T—— and Mr. C——. There had been labour pains for 48 hours, generally strong and forcing; yet the head rested on pubes, could be felt only by introducing the whole hand, and the os uteri had never been pressed upon so as to be fully opened. The cause seemed to be projection of sacrum, narrowing the upper aperture of the pelvis from pubes to sacrum. With the previous history of two labours, (where great time had been given), the long duration of present

pains, and the total want of progress of labour, there seemed to be no hesitation about perforating, and I accordingly did it. I think it should have been done earlier, and then the pains might have been allowed to go on and effect delivery after the head was perforated; but now I thought it right, with the hook and crotchet, to do what I could to get the child away, and I was 2½ hours before I could accomplish this. It was a large female child. The placenta soon separated, and the patient did well.

Case 46.

Mrs. B—— has had three or four children before; always with very lingering and laborious times—but children generally living, and no instruments employed, the presentation being natural—has had no child for 4½ years—present age 42 or 43.—Labour began on Thursday evening—pains not very strong till next morning, when the midwife remained with her—waters broke about eleven, when the midwife found the face to pubes—os uteri then dilated—violent and horrid pains, without change of head, until half-past one, when I went. Found a narrow pelvis with sacrum projecting considerably—head not fairly in the pelvis, but sinciput resting upon the pubes—occiput towards sacrum, and face towards anterior part of abdomen, but a little obliquely towards left side, so that I could feel the left ear of the child. I passed both blades of the forceps, and made them lock well together—but with all the force I thought it right to use, I could make no alteration in the situation of the head—indeed the head was so high up, that I could not pull enough towards the sacrum to help the head fairly into the upper aperture of the pelvis; and the force I employed only drew the head more tightly against the pubes, which was the chief resisting body. With powerful pains, a strongly contracted uterus after being two or three hours emptied of the waters, and the head so wedged, I could not attempt to turn. I thrice applied the forceps, to see if I could make an impression by getting a slightly different position, but without good effect; nor with my hand or fingers could I effect any alteration. When I had thus spent an hour and half with the woman, pains still rather strong, though occurring at longer intervals—Mr. R—— was sent for—before examining, he said, in such cases he used the vectis, and did not see what the forceps could do.—

After examining, he found the head much higher up than he expected—he introduced the vectis, and with a pain he made an effort to use it; but it slipt and did no good; so he immediately proposed opening the head. The pains were much abated—turning was impossible—and I saw no chance of using the forceps with effect; so that I really did not hesitate to sacrifice the child, which I had reason to believe was still living. A little after three o'clock, I perforated the head—got a good deal of the brain away, and when the volume of the head was thus diminished, getting hold of the head with blunt hook, I brought it down in five or six pains, and the business went on very well. It was a large male child. The woman recovered without any untoward symptom.

Case 47.

Mrs. L——, æt. 32 years. In first and second labours the forceps were used and children living. The third labour was as follows, June 17th, 1829. Face presentation—no progress for 12 hours, and labour going on six hours before that, with powerful pains—os uteri dilated, with a thick projecting flap at one part. I agreed with Mr. S——, that the forceps could not be applied, and that the labour could not terminate without assistance, which should not be deferred. Mr. S—— had been on the spot above 13 hours, and I formed my opinion on an interval of three hours; so we agreed to perforate, but the anterior fontanelle laid so over the pubes, that we could not get at it. A fine child was born—perhaps it had been dead some hours before we perforated, as it had not been felt to move.—This patient had no unfavourable symptom.

Case 48.

Mrs. A——, aged 33, in her fourth labour furnished the following difficult case.—Her three first labours were natural and tolerably easy—in this, commencing at full term, the midwife found difficulty, and sent for Mr. D——, who found the funis and an arm presenting, the funis having no pulsation. Mr. H—— was soon after with Mr. D——, and when an hour had elapsed, Mr. D—— came for me, and I found both arms presenting at, and indeed prolapsing through, the os externum. The side of the chest which presented had been opened. We agreed upon the

proceeding which I was requested to carry into effect, viz., to amputate both arms above the scapula, which I succeeded in doing. I found the head towards the pubes, and could get my finger into the fœtus' mouth. I could pass my hand into the uterus so as to feel the abdomen of the fœtus; but owing to the most distinct hour-glass contraction, I could not pass my hand high enough to feel the pelvis or lower extremities, these lying at the fundus of the uterus. I enlarged the opening into the chest, removed part of the ribs with the duck-billed forceps; got away the viscera of the chest, and chiefly those of the abdomen. I could get a hook upon the spine or into the mouth, with which I could have used any degree of extracting force, but it would have been unavailing, as it would have brought the head and abdomen together into the pelvis, if put on the spine, and the head only if in the mouth, but in a wrong direction. Above an hour I was thus laboriously employed, with my hand in a contracted uterus. I knew what was required, to get at the pelvis or lower extremity, but could not succeed. We meditated giving a large dose of opium; but at length the hour-glass contraction gave way. I passed my hand into the fundus of uterus; felt a thigh, also the placenta, which was adherent to the fundus; and getting a hook into the anus of the child, I readily brought down the pelvis, effecting a complete evolution, and in two pains the fœtus, of full size, was born. The inserting the hook into the anus answered so well that it should be recollected.—It appeared that the right side of the thorax had been at the os uteri, and was perforated. It was altogether a most difficult and perverse case; and near three hours were occupied in effecting delivery after the chest was first perforated. After clearing the chest and abdomen, my object (since the firm hour-glass contraction prevented my getting at the lower limbs or outside of the pelvis), should have been to get at the cavity of the pelvis and insert the hook in it; but I did not clearly manage this, and rejoiced when the uterus gave way so as to enable me to pass my hand up to the fundus of the uterus, and to succeed in the way I have mentioned. This woman had fever on the third day, but afterwards rapidly recovered.

Remarks.

There are few operations in Midwifery much easier to perform, or, in one sense, much more successful, than Craniotomy; and it is much to be feared it has on these accounts been far too frequently resorted to. I well remember that lecturers were in the habit of relating to their audience, with a desire to warn others against the cruel error, the circumstance of their having at various times received communications from former students, now become practitioners, boasting of their great success in Midwifery, they having had occasion to perforate only so many times in so many labours; the proportion being nevertheless far above any justifiable amount. There is no doubt that, if so disposed, the accoucheur may avail himself of this method of putting an end to suffering, without exciting any doubt in the mind of those present as to the necessity of its being done. The long continuance of severe pain, and great anxiety for relief, the knowledge of the existence of obstruction to the progress of the labour, requiring some kind of instrumental aid, and fear on the part of the attendants, pave the way easily for a dishonest or inefficient practitioner to plead successfully the necessity for Craniotomy, and to obtain a sanction to its performance. It is an easy operation; easy in a mechanical, but most difficult in a moral, sense; most repugnant to the feelings of a Christian; requiring all the fortitude which the mind of such a man is able to command, and which can only be commanded under the certainty that the operation is imperatively required, and that if it be not performed two lives must be sacrificed instead of one. Fortunately the art of Midwifery has arrived at so great perfection, that it is rarely necessary to destroy the life of a child to pre-

serve its mother; there are not many cases in this collection; and in some of them there was reason to believe the child was already dead, a circumstance which deprives the operation of all its horrors, and renders it rather a desirable proceeding. I performed it only twice in upwards of 1400 labours; and shall never forget the feelings of repugnance to the operation which possessed me at the time; but they were cases of extreme difficulty, and such I trust as to warrant and justify the act.

The preceding cases exemplify some of the circumstances in which this dreadful alternative should be adopted; and happy would it be if those who are obliged to resort to it, should be able to ascertain (which it seems may with care and attention frequently be done), that the circumstances which have occasioned the necessity for the operation, have also unavoidably deprived the infant of life. In all the cases related, eight in number, as well as in the two referred to as occurring in my own practice, the mothers recovered.

CHAPTER VI.

SPONTANEOUS EVOLUTION.

Case 49.

On the 23rd July, 1828, I saw the following case:—The patient in her third pregnancy, groaned a month prematurely of a dead child, the arm presenting. Mr. H—— was with her eight hours, unable to turn or to bring the child forth arm first. At length, declining to examine for a short time, he found the feet had come down, and the child was soon born, spontaneous evolution having taken place. Two days afterwards, the patient having eaten very improperly of stuffed pork, was seized with pain in the right side of the loins, extending to the right iliac region and hip. She was bled to fainting, and I saw her eight hours after the pain commenced—pain then great—perspiration—pulse 100—tenderness extended over great part of the abdomen. She was cupped, fomented, well purged—blister— dieted. Next morning I learned she was free from pain. She recovered.

The above is the only case I have found in Mr. Crosse's notes, referring to the subject of Spontaneous Evolution. In one instance only have I met with anything of the kind in my own practice; it was an interesting case, and as it was published in a journal which enjoyed but a brief career, and has now ceased to exist,* I am induced to transfer it to these pages for the sake of the practical suggestions it affords.

* Case of Back Presentation, with partial Spontaneous Evolution of the Fœtus. By E. Copeman, Esq., M.D., Norwich.—*British Record of Obstetric Medicine, &c.*

Mrs. K——, a delicate woman, of middle age and scrofulous complexion, whose mind had been much distressed by the irregular habits of her husband, sent for me at 2 p. m. on Friday, November 19th, 1847, to attend her in labour with her third child. The waters had suddenly gushed from her at ten o'clock in the morning, and continued to escape in large quantity; but she had no pain or other symptom of labour; she said she was very much smaller, especially at the waist; and from the weight and uneasiness which she felt on moving, supposed the child was "at the birth," and would be born quickly if pains would come on. The os uteri was soft and dilatable, not dilated; but I could feel no presentation either at the os or through the walls of the uterus by examination with the finger. Externally, the abdomen seemed larger from side to side. After waiting two hours, during which there was no uterine contraction, I examined again, but could not touch any part of the child; so I left, with directions to be sent for when labour appeared to be coming on. No further summons arrived until after six o'clock the next morning; there had been occasional pains for about two hours; she was languid and fearful; convinced that something was wrong, from the unusual nature of her sensations; and apprehensive about the result of her labour. The os uteri was fully dilated; and the child was now discovered to be lying across the pelvis, with the back presenting; but I could feel neither shoulders nor hips with the finger, so as to be able to ascertain in which direction the head was situated. Neither could I feel spinous processes or ribs, but determined the nature of the presentation more from the breadth and flatness of the presenting part; and a mark on the skin made with my finger nail, indicated after birth the correctness of the diagnosis. As the contractions of the uterus were but slight, and occurring at long intervals, I took the opportunity of sending for my partner, that he might witness the case, and be at hand to assist if required; meanwhile the patient took some nourishment, and was encouraged to submit with fortitude to the proposed operation of turning. During this time she sat up in the bed, and said it was the easiest position. In less than two hours, Mr. Evans arrived; the patient was then properly placed in bed, and I prepared to turn without further delay; but to my surprise I found the pelvis filled; there had been several good pains just be-

fore, which had forced the back of the neck and shoulders downwards at the right side of the pelvis. I feared valuable time had been lost, and that turning would now be very difficult to accomplish. I at once endeavoured to pass my hand over the right side of the child towards the pubes, but in doing so I felt the child recede, and therefore confined myself to raising the child's pelvis with my flat hand and fingers; whilst the pains forced down the occiput, the head descended, and delivery was quickly completed. I think if I had waited a little longer, spontaneous evolution would have occurred, and the child have been born head foremost, even without manual interference. The child was a full grown male, lively and vigorous; the placenta followed easily.—Both mother and child did well.

The case above related is interesting, not only as being one instance among thousands of the power of nature to obviate difficulties seemingly not easily to be surmounted, but also in several other practical points of view. In the first place, it exhibits the signs by which presumptive evidence of cross presentation may be obtained, before the position of the child can be ascertained by the usual examination, viz.,—the sudden escape of liquor amnii in large quantity, followed by a total cessation of pain or other symptoms of labour for many hours; the difficulty of reaching the presenting part with the finger, the chief protuberance visible externally being at the lower part of, and across, the abdomen; the uneasy sensations produced by lying down or leaning to one side; and the feeling of bearing down even when the child is lying above the brim of the pelvis, probably from lateral distension. Secondly, it shows that in presentation of the back, the spine and ribs, which are said to be the chief diagnostic marks, cannot always be distinguished. I could not feel them when I examined the infant after birth, owing to its good condition; the bones were too well covered with soft parts to be distinguished by any common degree of pressure with the finger. The mark made by my finger nail was directly over the spine, a little above the level of the inferior angle of the scapula. Thirdly, the history of this case points out the necessity for carefully watching the processes by which nature succeeds in overcoming difficulties, so that we may take them for our guide when the assistance of art is required. In this instance, although the evolution had evi-

dently commenced spontaneously, it appeared to be aided by the upward pressure of my fingers against successive portions of the child's back; and from the ease, comparatively speaking, with which the nates glided upwards, it becomes a question whether in back presentations it would not be better to attempt to push up the breech, than, as has been recommended, to raise the shoulders and depress the breech. By attempting to favour evolution in this direction, we may perhaps raise the shoulders without moving the head, owing to the flexibility of the neck; but in addition to the smoothness and rotundity of the breech, which favour its ascent, we have the advantage of being able to direct our pressure upon the very part we wish to move. It is not to be supposed that in back presentations generally, the usual operation of turning can be dispensed with; but would it not be advisable in all such cases to make an attempt to elevate the breech, whilst introducing the hand for the purpose of turning? It might be successful; and if otherwise, would not probably increase the difficulty of turning.

ARTIFICIAL PREMATURE LABOUR.

Case 50.

March, 1827. Mrs. S—— is now 30 years of age, and this day, in company with Mr. ——, I attempted to induce premature labour by dilating a little the os uteri, and drawing off about a pint and half of the liq. amnii. She calculates that she is between 31 and 32 weeks gone in her 5th pregnancy, and the following is the history which led to our adopting, and seemed to justify, this measure:—Four years and a half ago, her first labour took place at the full period, and after the os uteri had been 48 hours fully dilated without the head descending lower than the brim of the pelvis, the head was opened. Eleven months after this, her second labour took place, and after the os uteri had been 15 or 18 hours fully open, the child's head was perforated and delivery effected with a favourable issue to the mother, who was soon again pregnant and miscarried. Her 3rd labour happened 2½ years ago, and I was then called in for the first time; the head had already rested many hours at the brim of the

pelvis, with a fully dilated os uteri, and I at once opened the head and effected delivery. The parents of the patient, as well as her husband, had been put in full possession of the grounds on which this treatment was proposed; and the preparatory treatment in regard to diet and opening the bowels strictly attended to. I had stated some causes of failure not noticed by others—having lately learnt from a Mr. Walker, a retired practitioner at Halesworth, that in a case where premature labour was induced on account of a narrow pelvis, the patient was pregnant with twins; which of course died, though had the labour not been prematurely induced, it is possible, from each twin being commonly less in size than a single child, and labour generally from over distension coming on spontaneously before the full term of utero-gestation, that the children might have been born alive. It therefore becomes important to take into consideration whether there be twins; which can only be suspected from the rapid increase of bulk, or feeling the movements of two children, or the bulk being very great at a comparatively early period of gestation.

Would it not be possible to detect the presence of twins in the uterus at a late period of pregnancy by means of auscultation?

The patient was healthy, though of rather delicate frame. I found the soft parts very dilatable, and os uteri very yielding—the sacrum was very prominent, and pelvis very narrow. I could not feel the child's head, but thought I felt a hand or a foot, and was inclined to say the latter. Mr. T—— spoke positively about feeling the head. I should here state, that after Mr. T—— and I had repeatedly examined, and stated our separate and discordant opinions, we agreed if the child's head were not the part presenting we would proceed, not deferring it to a future day in expectation that the head might come down, or a turn of the fœtus happen, as I think Dr. Merriman, in his paper in *Med. Chir. Trans.*, says may happen; but feeling fully justified in adopting our intended measures, although a hand or a foot were the presenting part—although it would almost annihilate all chance of a living child, it would be better to the patient than allowing the full term to be completed, when a foot or arm presentation would, with such a contracted pelvis, be a case of much greater difficulty, and consequently of greater danger, than what she had experienced in her three previous labours.

I introduced my whole hand into the vagina. Above a pint of liquor amnii was drawn off by my piercing the membranes with a female catheter. We were in the house 2½ hours after this, and left the patient sitting up, complaining occasionally of slight pains that seemed to depend on uterine contraction—the waters continued to dribble away and were tinged red.

Two days afterwards, Mr. T—— wrote to me that "Mrs. S—— was delivered of a girl, very large in size, after about 30 hours from the drawing off the liq. amnii; the difficulty was considerable with the head through the brim of the pelvis, and I must acknowledge you were correct as to the presentation. She was greatly fevered yesterday, and on my first coming this morning, she expressed herself really ill—pulse very quick, and intense head-ach."—The child was dead. She recovered without any difficulty.

Case 51.

K——. In her first labour a living child was born at seven months, a girl now alive. She also once had twins, both born alive; but in three pregnancies the child's head had been opened. She thought herself gone seven months and two weeks at the beginning of this July; and, having on a former occasion suggested artificial premature labour, I proceeded in this measure on Monday, 5th July, previously reading on the subject, and possessing myself of all the cautions enumerated by Dr. Merriman, in vol. 3, p. 123, of the *Med. Chir. Transactions.** I asked

* From Dr. Merriman's paper above alluded to, it appears that out of forty-seven instances of distorted pelvis in which premature labour was induced, at least *nineteen* children had been born alive, and capable of living; and there is no record of the deaths of any of the mothers, although several were attacked with shivering and fever, rendering their condition for a time hazardous. It may be useful to append his concluding remarks and directions:—"In order to guard against any abuse of this method of practice, it seems expedient that some fixed rules of conduct should be observed respecting its adoption. What these rules ought to be, I do not presume to determine, but shall content myself with subjoining such limitations and cautions as appear to me to be indispensable.

1. As the primary object is to preserve the life of the child, the operation should never be performed till *seven complete months* of utero-gestation have elapsed; and if the pelvis of the mother be not too much contracted to allow of it, the delay of another fortnight will give a greater chance to the child of surviving the birth.

Mr. ——, my pupil formerly, to be with me, and there happened to be present for the hour a young Doctor from Philadelphia. I readily introduced my hand into the vagina, and found os uteri easily dilated to size of half a crown, under the fingers used for the purpose. I also found that the head was presenting. I detached the membranes from the uterus even to a greater extent than I dilated the os. It had been my intention, at this trial, to dilate the os only, and to wait the result for a few days ; but as all seemed so easy, I at once asked for a knitting-pin, and with it perforated the membranes where they presented at the os, making only a small aperture. The liquor amnii gradually dribbled away, and on the next day (Tuesday) was still doing so, with very little apparent disturbance; but at five o'clock on Wednesday morning I was summoned, and found a living active child already born (it appeared short of eight months), and the placenta soon followed in due course. I learnt that regular pains had

2. The practice should never be adopted *till experience has decidedly proved* that the mother is incapable of bearing a full-grown fœtus alive.

3. It is sometimes necessary to have recourse to the perforator in a first labour, though there may be no inconsiderable distortion of the pelvis ; therefore the use of this instrument in a former labour is not *alone* to be considered as a justification of the practice.

4. The operation ought not to be performed where the patient is labouring under any dangerous disease.

5. If upon examination, before the operation is performed, it should be discovered that the presentation is preternatural, it might be advisable to defer it for a few days; as it is possible that a spontaneous alteration of the child's position may take place; particularly if the presentation be of the superior extremities.

6. The utmost care should be taken to guard against the attack of shivering and fever, which seems to be no unusual consequence of this attempt to induce uterine action, and has often proved destructive to the child, as well as alarming with regard to the mother. The peculiar circumstances under which the operation is performed, and the habit of body of the patient, will determine the accoucheur either to adopt a strictly antiphlogistic plan, or to exhibit opiates, or antispasmodics and tonics.

7. In order to give every possible chance for preserving the life of the child, it will be prudent to have a wet-nurse in readiness, that the child may have a plentiful supply of breast-milk from the very hour of its birth.

Lastly, a *regard to his own character should determine the accoucheur not to perform this operation, unless some other respectable practitioner has seen the patient, and has acknowledged that the operation is advisable.*" Op. cit.

come on in the course of the night, and continued several hours until the above result. The woman had no trouble ; the child was nourished at the breast, and doing well when I took my leave a week after delivery, so that nothing could have answered better.

August 18th. The infant still lives, but I do not think it will survive many days.

Mr. C——, of ——, informed me, subsequently to my operation on this patient, that he had induced premature labour repeatedly—twice in one patient, whose two children are living.—He remarked, his idea was to imitate the natural processes as far as he could ; so that he would not dilate the os uteri, nor open the membranes there, but just open the os sufficiently to get an instrument through it, and pass this to one side, so as to pierce the membranes a little way from the os ; then the liq. amnii would escape more gradually, and indeed (as he found in one of his cases), the child be expelled with great part of the liq. amnii retained until the child was born. He feared (and this idea had I confess occurred to me) that if all the liq. amnii escaped, and suddenly, before delivery was much advanced, it might be injurious to the fœtus, and interfere with its being born alive. The rules, to imitate as far as possible the natural course of things, and avoid the too early, precipitate, and total escape of the liq. amnii, are certainly good.

Case 52.

Mrs. R——, in her first labour, was delivered, after considerable difficulty, by opening the head. In this second labour, I attended her, and when she was near eight months gone, I induced premature labour in the usual way. It came on 20 hours after I let off the liquor amnii, and the patient did well. Child born alive. A vesico-vaginal fistula, which had followed her first delivery, still remains.

CHAPTER VII.

PLACENTA.

PRÆVIA—RETAINED—ADHERENT—PREVIOUS SEPARATION.

Placenta Prævia.

Case 53.

Mr. J—— summoned Mr. S—— and me to a Mrs. G——, near 40 years old, who had not for 15 or 18 years been pregnant; and now, having attained the full term, had flooded during the day, and lost so much that she was pale as a sheet when we went, though the os uteri was only the size of a shilling—it was a placenta prævia—turning seemed to be required without delay, and it was accomplished in 15 or 20 minutes—fœtus dead; the placenta was brought away—no great loss ensued—a dose of ergot given, and shortly Mr. S—— and I left the patient, who, though equally pallid, had a very perceptible pulse. Spirit and even æther as well as wine were given, when she became faint—she got restless and tossed about—pulse became small, imperceptible. I was summoned again two hours after I had left the patient, in order that transfusion might be tried—the case being clearly suited for such a trial, the direct means of removing the morbid state. But the patient had actually expired ten minutes before I got there.

Case 54.

I met Mr. —— and Mr. —— at a woman's in King-street, aged 35 years, with 9th pregnancy, and gone to near full period; who had flooded several days, and this morning profusely, losing several pints of blood, and the os uteri was plugged by the placenta.

Mr. J—— immediately delivered—the feet were presenting, and the child was stillborn and could not be revived, though living when delivery commenced. No hæmorrhage during delivery nor after, and we left the woman with a fair pulse.

Case 55.

Mrs. L——, the mother of several children—nearly eight months gone in pregnancy—three weeks ago she had a loss, and it recurred to-day profusely. Mr. S—— sent for me—I found the patient faint from excessive loss—labour pains had just become frequent and rather strong—the placenta was projecting through a moderately dilated os uteri. Mr. S—— asked if labour could go on to its termination without loss? I thought more loss inevitable and that turning was urgent, so I did it—the head lay just above the placenta. I could only get one foot, and by this delivered in a few pains—there was scarcely any loss; and severe uterine pains continued after the delivery, proving a well contracted uterus—but so great had the loss been, that for five or six hours the patient continued faint, and nearly a pint of brandy was given by Mr. S—— before syncope was entirely removed.—The patient recovered, without any unfavourable symptom.

Case 56.

Mrs. C——, æt. 33 years; 7th pregnancy; arrived at supposed full term, or very nearly. I was called at 4 p. m. March 4th, 1840. A fortnight before, there had been loss, which had since recurred frequently; and to-day at 2 p. m. there was much loss and labour pain. I found the patient pallid—pulse just perceptible—indications of profuse loss in the bed—no fire in the room; covered only with a sheet, though frosty weather—extremities and surface of the body very cold; but vagina very hot, filled with coagula, and the membranes partly in the vagina, and a portion of the placenta projecting through a relaxed and dilated os uteri. I immediately turned, being convinced it was placenta prævia—using the left hand, I readily got the feet, and without much delay, a full-sized fœtus was extracted—it was stillborn, though I had felt it move in delivery. I brought away the placenta, which indicated by its shape a marginal projecting portion which lay over the os uteri; so that the main mass of the pla-

centa was attached to the uterus, and it was owing to so small and marginal a portion being at os uteri that the hæmorrhage was less rapid, allowing of timely assistance. I had ordered a fire on first entering the room; and with covering of blankets, dry linen, and some warm gruel taken with a little brandy, the patient was quite rallied when I left, and the circulation beginning to be pretty equally distributed over the body.—This patient recovered.

Case 57.

Mrs. L——, æt. 37; 9th pregnancy, and gone to full calculated period—when I was called Dec. 30, 1833, by Mr. ——, who was in attendance. I learnt that three weeks ago there was a sudden and profuse loss of blood—a fortnight ago it returned. At eight yesterday morning, Mr. —— was called on account of flooding, with slight labour pains—both flooding and pain had ceased when he got there. He was called again at eight in the evening, but did not send to me till 1½ this morning, although there was flooding, and he suspected the placenta presented—he committed the usual mistake of a young practitioner in such cases, by thinking labour not advanced, because the uterus was high up, and no child's head presented. The fact is the placenta occupies the space, and the child's head does not descend as usual so as to be easily felt. I found the woman pallid, exhausted, cold, with a pulse just perceptible—placenta at os uteri, which was considerably dilated—the head felt presenting above placenta; membranes entire. I at once proceeded to deliver by turning, and accomplished it expeditiously—the os uteri with great difficulty admitted my hand—the fœtus was dead—I removed the placenta, and there was very little loss during this proceeding, no more than in a common case after it. Gruel, with wine or brandy, was given—warmth applied—but the pulse could scarcely be felt—hands deadly cold—face and lips pallid—thus it went on for above two hours after delivery; when seeing the patient must soon die, and not wishing to delay the trial till jactitation was present, I injected six ounces of blood into the right cephalic vein, which I took from her husband's arm. Whilst this was doing, the patient became more distressed—the pupils dilated—purplish pallor of face—pulse no longer perceptible—death within an hour after. The transfusion, though done readily, and as far

as I can judge, in a right manner, not only failed to rally, but really seemed to have a bad effect. Still, looking on the case as hopeless, I felt justified in undertaking transfusion; and though it certainly had no good effect, I should not have been satisfied to have neglected employing it in a case so exactly suited to it.—The mistake here was in the surgeon not calling advice as soon as he suspected a placenta prævia; when artificial delivery, so clearly unavoidable, so urgently called for, might have been *timely* and successfully adopted.

Case 58.

April 1, 1835. I was called by Mr. D—— and Mr. G—— to a single woman, aged 29 years; first pregnancy; health bad, with pulmonic cough; seven months gone—had loss till she was greatly reduced—placenta prævia distinctly felt—os uteri size of half a crown. I advised immediate delivery, which was done; and two days after she was doing well.

Case 59.

Mrs. B——, æt. 33; fifth pregnancy—no child for four years past. When two months gone began to have loss, which recurred often—once or twice profusely, so that for weeks Mr. D—— was in daily attendance. Now, April 26th, pains came on in the morning, with loss till the patient was pale, with a small pulse. I was called after four hours continuance of labour pains—the placenta then presenting—child's head could be felt by the side of it, the finger being admitted into the os uteri, and membranes just ruptured. Afterwards funis descended—pains went on regularly without loss—all I advised was to wait regular effect of pains (plugging could not be tried, and the loss was not going on), and if there came loss, to expedite delivery by common lithotomy forceps, when the child was far enough protruded at os uteri. No such aid became admissible, the fœtus being expelled (and it had been dead several days), and the placenta with it, three hours after I was called in consultation—after this, all went on well.

Case 60.

April, 1842. Mrs. S——, aged 27 years—in first and

second labours, difficulty, but children alive, vectis I believe used. In her present (3rd) labour she was within a fortnight of the full term of gestation—three or four days ago, she had a sudden loss of blood, which excited suspicion—to-day, whilst up and in her usual room, a profuse gush took place from vagina—she is stated to have lost two or three pints of blood; was faint, and with difficulty conveyed up-stairs to her bed. There was uterine pain at the time of this loss, but it did not recur. Mr. E—— was very soon with the patient, and Mr. C—— came shortly after. I was sent for, and although three or four hours had elapsed, no hæmorrhage had returned; but the os uteri was enough dilated for the placenta to be felt there. The woman, who had continued very faint, was rallied. I observed that the blood had gushed down to her heels, the stockings still on being stained with it. I advised delivery by turning, as waiting till hæmorrhage should return might lead to loss of life, and to means of delivery being adopted when too late. Mr. C—— proceeded to dilate os uteri—found edge of placenta only over it—and passing between the membranes (which were entire) and the hollow of the sacrum, the child's head could be felt. Mr. C—— hesitated about proceeding, as the head was so low. I then examined, and could feel the fingers of one hand lying on the head of fœtus; so I knew that if the head were allowed to descend, we should have a hand presenting. I still advised delivery—Mr. C—— therefore proceeded through the membranes to reach the feet of fœtus, which he got, and delivered a stillborn boy—it had been felt alive since the sudden hæmorrhage—the placenta followed quickly, and there was no further loss. The placenta was healthy, and the portion which had been over os uteri, being not one-sixth of the whole, was observable. I consider the practice was safe and right to deliver, as hæmorrhage must have recurred, and evacuating liq. amnii would not have suited, nor proved effectual.—The patient did well.

Case 61.

Mrs. ——, æt. 39, mother of a large family, had repeated hæmorrhage during latter months of present pregnancy, so as to create a suspicion of placenta prævia—and on Monday night, March 13th, when advanced to near the termination of gestation,

she again had great loss. At four o'clock in the morning, when Mr. C—— was still present, there was a sudden loss, said to be as much as five or six pints—syncope came on—sickness for some hours, so that nothing was retained—pulse not to be felt. I was sent for, a distance of 12 or 14 miles, and arrived at nine o'clock on Tuesday morning—found patient pallid, lips quite pale and bloodless, but sickness had gone off, so that mild nourishment and some stimulus had been retained, and pulse was just perceptible, very rapid—no outward loss for some hours. I found vagina occupied by coagula, os uteri open to size of half a crown, and placenta presenting. The necessity for delivering by turning was obvious—hitherto there had been no uterine contraction; but whilst we were waiting a little that the patient might be rallied further by milk gruel and a little brandy, a pain came, and I at once proceeded to deliver, using left hand. Os uteri dilated readily. I passed the placenta, and did not break through the membranes till some way above it and above sacrum, and then came directly at the feet of the child—delivery was accomplished with scarcely any loss. I could not avoid the funis coming down before the body of the child; there was no pulsation in it, and the child had apparently been dead several hours. I left the patient with a very perceptible, and very improved, though still very rapid, pulse, and nourishment was retained, so I entertained a prospect of recovery. A few weeks afterwards, I learnt that the patient did recover, but was then suffering from phlegmasia dolens.

Case 62.

Mrs. —— believed herself just eight months gone in pregnancy, when I was summoned to her by Mr. ——, on Sunday, and learnt the following history:—She is aged 17 years; one month, if not two months, before last *Friday*, and again on *that day*, she had hæmorrhage from the uterus—on this last occasion the loss was considerable, and as there was a return on the next day (Saturday), Mr. —— examined, and felt convinced the placenta was at the os. I found it so on examining after my arrival —a soft bulky mass occupied the uterus within the os, and prevented the fœtal head being felt. I enjoined suitable precautions, plugging with lint soaked in vinegar, if the loss recurred—and as the patient was several miles from Norwich and from her surgeon,

I suggested, that if all was quiet enough, she should in a day or two be brought to Norwich. But this was prevented by her being seized the next Tuesday afternoon with sudden and profuse loss; and when I arrived at 6 p.m., I learnt from Mr. ——, that for some hours there had been slight labour pains. On examining, I found the os uteri a little dilated, so as to receive my finger, and I believe I ascertained that the great mass of the placenta lay on the pubic portion of the uterus, only a marginal portion of it corresponding with the os. The plan we pursued was to plug the vagina with lint soaked in vinegar, and allow labour pains to go on (so long as the loss was not much), that labour might progress, and the os uteri be more dilated, to facilitate delivery should it become necessary to accomplish it by art. After midnight the loss from the vagina increased, and became at length very considerable. We were obliged to remove the plugs—as soon as we emptied the vagina, it filled with blood. I accordingly proceeded to deliver, very gradually dilating the os uteri until my hand was admitted. My hand, as a plug, prevented loss, and allowed me to take time. I found that the great mass of the placenta lay anteriorly, and readily passed my hand on the sacral side, passing the margin of the placenta, and thus piercing the membranes and getting the feet of the child. (The head presented.) Again I proceeded most slowly, using a little traction only during pains. Thus the fœtus was gradually brought down, and when I had got it so low that I believed the cord to be pressed upon, I endeavoured to complete delivery as quickly as I could, to save the child. But there was unavoidably so much delay, that the child was still-born, although known to be living shortly before I proceeded to deliver. The placenta soon followed without any great loss; the parts which had been separated, answering to the os and its margin, was evident from its appearance; it was rough, jagged, injected with dark blood, whilst all the rest ($\frac{7}{8}$th of the whole surface), was smooth, entire, and presented no such appearance from clotted blood. There was no hæmorrhage after complete delivery. The patient gradually, though slowly, regained health.

In this case there was no question about separating the placenta, as Professor Simpson advises, to arrest the hæmorrhage. When proceedings were required to arrest it, to detach the placenta

entirely for that purpose would have inevitably *sacrificed the child;* and although *this result* did transpire, every effort was made to avoid it.

Retained Placenta.

Case 63.

A poor Irish woman, aged about 22 years, was attended by my nephew in her first labour. After a tough tedious time, twins were born, both dead. One had died very recently, probably within 12 or 24 hours, and was of healthy full size—the other was semi-putrid, a month younger in reference to size, and had doubtless died several weeks ago. Did the death of this interfere with the life of the other? I do not think there is much reason to suppose so, since premature labour was not induced. I was called, because after an hour the double placenta remained. I found the os uteri so contracted that there was difficulty in my introducing the hand—I nevertheless did so, and removed the placenta—there was no disease leading to its retention, and all did well.

Case 64.

Mrs. J. L., æt. 29—full term of first pregnancy. After tedious labour, in which the pains intermitted for many hours at a time, and going on between two and three days, was delivered of a dead child at 6 p. m. on Friday, May 6th, 1836. The placenta not following, and the funis being somehow broken off, Mr. R——, after an hour or so, tried to remove the afterbirth with his hand, but could not, and says he found hour-glass contraction. He sent for Mr. W——, who arrived at 8 p. m. Before Mr. W——'s arrival, but I know not whether before or after the birth of the child, an infusion of ʒi of ergot, in two doses, had been given. Mr. W—— examined soon after his arrival; but, removing his hand to take off his coat that he might proceed to introduce the full arm to extract the placenta, the patient would not let him again proceed—and thus things rested, the patient not having perceptible afterpains, until I arrived at half-past five on Saturday morning. I proceeded to introduce my left hand (after spending an hour in the house, hearing the history of the

case, and examining the patient), and never felt such pressure as the uterus made on my hand; so much as to make me complain, and to convince me that I could not long bear it—by perseverance, and also fortitude I may say, I got the hand to the fundus uteri, where the placenta lodged, directly at the very fundus. I could just feel the placenta—it could scarcely be called hour-glass contraction, because all the lower three-fourths of the uterus were contracted, leaving only the cavity at the fundus. Under such extreme pressure, I could only proceed cautiously, and had not power enough to expand my fingers to grasp the placenta—indeed I suffered so much, and felt the case to be so difficult, that I exclaimed I could not bear it if I did not in a minute or two do something, and that I could not venture a second attempt. By further efforts, and the arm introduced quite to my elbow, I got above a third of the lowest part of the placenta within my fingers—then I felt that if there were any morbid adhesion, I could bring away only what I grasped. I took the chance, and slowly extracted, under expulsive efforts of the patient, and got away the placenta entire; proving there was no morbid adhesion.

The placenta was remarkably small, and its vessels empty; all the blood having apparently been pressed out of it by the uterus. There had been but little loss of blood during or after labour, and I found little blood in the uterus. It would seem that this was partial contraction of the uterus in an extreme degree, shutting up the placenta at the fundus.—The case for ergot is when there is feeble contraction, usually accompanied by flooding more or less. Was ergot called for here? and might it not rather have increased the contraction by which the placenta was retained? I think the ergot had this effect, and was not called for. The patient had suffered no severe afterpains—still the uterus, I believe, was firmly contracted and constantly so—pains are experienced in the change from relaxation to the contracted state—permanent contraction would not be painful. The patient was not greatly exhausted, and had a good pulse; being healthy and rather stout. The rules and precautions before I left were—rest, composure, rigidly low diet—3 or 4 grs. of calomel night and morning—leeches at hand should there be indication of inflammation of uterus, the mischief principally to be apprehended. The removal of the placenta, it must be remembered, took place

at six on Saturday morning. The patient up to Tuesday morning was supposed to be going on so well that her brother, a surgeon, who had up to that time remained, then left. At 12 that day she had some pain in the body; but it was thought griping, and was relieved by fomenting. Next day she had sickness, and on Thursday, great retching; and I was not called till evening, when I found her actually *in articulo.* Leeches had been applied in the course of the day, but at too late a period, and when it was scarcely proper.—In this case there had been little pain—probably there was no peritoneal inflammation or effusion; it was more like uterine phlebitis, so insidious as to deceive the attendants, the patient expressing herself cheerfully; though to the experienced eye, I think it would have been evident, that from an early period after delivery, she was doing ill, and for two or three days might have been pronounced in an almost hopeless condition. She died whilst I was there, at one on Friday morning, being sensible to within her last moments, and struggling with interrupted respiration to a degree I have rarely witnessed. I suppose dying from failure of heart's action, so impeding and stopping at length the breathing, whilst nervous energy remained.—No inspection.

Case 65.

A woman in her third labour—symptoms indicated the child was dead some days before labour came on—the child, born after six or eight hours of pain, proved to have been dead a week or two. The placenta not following, Mr. W—— gave ergot, and introduced his hand; but not succeeding, sent for me and also Mr. B——. I was requested to proceed. I found part of placenta without the external labia—the rest was in the vagina, and I readily brought all away.

It serves as an example of a young practitioner taking fright unnecessarily.

Adherent Placenta.

Case 66.

Mr. S—— called me to a woman in first labour, who had been all night complaining—child born about an hour ago—the

placenta would not separate; flooding was going on to exhaust her, and he could not get his hand into the uterus fairly to bring away the placenta. The woman was pallid; had lost very much; was still losing; a slender funis was entire. I saw a necessity for removing the placenta, which I did, passing my hand to the furthest part of it, and beginning by detaching that. I really thought, rare as are such cases, that the placenta here adhered preternaturally to the posterior part of the uterus some way above its neck. Flooding ceased on removal of placenta (which was torn in two portions), and I left the woman with a good pulse, after cordials had been given. She recovered.

Case 67.

Mrs.——, æt. 41; fifth pregnancy; arrived at full term; the child, a girl, born after a few pains, before Mr. —— got to her. Three and a half hours after the birth of the child, I was called by Mr. ——, who stated, that the afterbirth adhered, and was still in utero—no particular hæmorrhage going on. Mr. —— had twice or thrice introduced the hand into the uterus, but not succeeded in removing the placenta. On examining, I found great part of the placenta in vagina, but a part was still attached to the uterus, and I introduced my hand and detached this part. There was not any morbid growth; it was simply delay in the separation of placenta, probably for want of uterine contraction, and I gave a most favourable prognosis; the surgeon had taken alarm too soon; better so than too late. Next day all was doing well. No bad symptoms ensued.

Case 68.

Mrs. B——, æt. 21; had miscarriage at five months in March last; now approaching full term of second pregnancy; tedious labour, attended by Mr. P——; afterbirth did not come away for three-quarters of an hour, and as there was hæmorrhage, and part of placenta was in the vagina, Mr. P —— having called Mr. B—— to his aid, removed the mass by introducing his hand; and he says, that it was partially adherent to the uterus. On two following days, there was rigor—fever—pulse got to 130—poultices to the abdomen, where pain and tenderness were felt over the left ovarium—leeches—poultices—purges—and on evening of

third day I was called. Pulse then under 100. I thought there was no general peritonitis—directed calomel to be added to ant. tart. and opium at night; reserving leeches and blister. On fourth and fifth day had a favourable report. I think there had been some inflammation of part of the uterus or left ovarium. This patient did very well afterwards.

CASE 69.

Mrs. P——, æt. 27; first labour. Mr. —— attended, and after five or six hours, with not very severe pains, a stillborn child was brought forth, but difficulty arose as to the placenta.—Mr. W—— was called—each of these gentlemen tried to detach the placenta, adhering to fundus, but could not, for neither could pass his hand through the hour-glass contraction; so I was called three or four hours after delivery. I did not examine at once, but took time—cheered the patient—had a cup of warm tea given to revive her. When I did introduce my left hand, I found so close a contraction of the body of the uterus upon a small portion of the edge of the placenta and funis, that I really thought there was scarcely any prospect of my passing this to get at the mass of placenta still adhering to the fundus. In 15 or 20 minutes, however, and with right hand on abdomen, pressing and fixing the fundus uteri in that direction, I was able to use more force; and, my hand being so very small, I passed the isthmus; got fairly to the placenta, which I detached; for it was still adherent, I would not say *morbidly*, or by any *morbid structure* on either side, placental or uterine,—but adherent, because there had not been contraction of the fundus to detach the placenta, to effect the *décollement*,* separation. However, I detached it and got it away entire, leaving the woman in a promising condition. She recovered very favourably.

* *Décollement*, the French word, is better than separation. Morbid adhesion, if thereby we mean adhesion by *morbid structure*, is rare; but adhesion from *morbid action*, or *inaction* of uterus, is far more frequent. When from inertia uteri, the décollement is not effected, but the natural adhesion of placenta to uterus remains, it is a very firm adhesion—the two tissues are like one substance—and the inexperienced are sure to call it morbid adhesion, as if from morbid texture, whereas it is only morbid action or inaction.

Case 70.

Mrs. T——. æt. 35; eleventh labour. Placenta resting at fundus, and imprisoned by hour-glass contraction. I was called one hour after the birth of the child—could just get my hand through the contracted part—so I detached and removed the placenta. The patient was very low, and I waited three hours till the pulse rallied. Several days after, she was doing well, but had been set back by a large dose of castor oil given by the nurse. She had a perfect recovery.

Previous Separation.

Case 71.

Mrs. P——, mother of 9 or 10 children, and above 40 years of age—advanced to the end of eight months in pregnancy—the preceding evening she rode out with her husband, and was put in some alarm, but nothing more. At 10 o'clock a. m., Aug. 28th, 1840, Mr. G—— was called on account of faintness—no labour pains—os uteri was dilated—there was some watery loss *per vaginam*, but not any hæmorrhage—the faintness increased. Mr. S—— was after a while called, and tried delivery by vectis, being able to get at the head of the child, but no delivery was effected. I arrived at one o'clock, and the patient had just expired. I saw the napkins—there was watery loss tinged with blood, but actually no external hæmorrhage. Mr. G—— immediately cut into the uterus, and removed a male fœtus, very large and perfect for eight months, but we could not revive it. Uterus contained four pints of blood, chiefly coagulated. Placenta situated at upper and posterior part of uterus, $\frac{3}{4}$ths of it detached and $\frac{1}{4}$th of it still adherent. Thus internal hæmorrhage from separation of a great portion of the placenta, was undoubtedly the cause of the fatal result. "Previous Separation of Placenta" is the proper title. This happens to persons of relaxed fibre, who have had several children; and not to the young and robust. It is surely rare in the lowest class of females; I scarcely ever heard of a case among them.

Case 72.

Mrs. B—— has had four or five children—advanced in pre-

sent pregnancy to within a fortnight of the full term—sustained a sudden fright on the evening of October 27th, 1840, and next morning there was suddenly a loss of a pint or more of blood from the uterus. Mr. S—— called me to the case—os uteri slightly dilated—no pains—on examining, we felt the membranes and child's head; certainly no placenta at os uteri. We thought there must be a partial separation of the placenta to account for such a considerable and sudden hæmorrhage. The membranes were ruptured—liq. amnii escaped freely; labour came on in three or four hours, and was quickly terminated with the birth of a dead child. Where the placenta is extensively detached prematurely, the child is likely to be stillborn.

Case 73.

Mrs. R——, æt. 39; third labour; full term—the membranes broke, after a few pains, on the 26th Sept., 1835, and liq. amnii dribbled away; but the patient went on free from pain till the morning of the 29th. Then labour progressed; there was also flooding, and after five or six hours I was called in by Mr. D——. The patient for two hours had flowed considerably—was faint, pale; rapid small pulse, some sickness; jactitation. I found scarcely any loss now going on, though the patient often complained of great faintness. Os uteri dilated to size of half a crown and dilatable. Delivery seemed the only way to relieve; I suspected hæmorrhage into the uterus, as I found that the placenta was not presenting. It happened that the breech presented; and when in examining I passed my finger between the thighs of the fœtus, rupturing the membranes there, a gush of blood took place, with much coagula, proving the uterus to have contained much blood. All assistance practicable being given, the fœtus was born, coming with the back to pubes—it was dead—the placenta, which was small, flaccid and empty of blood, immediately followed, and with it several pints of blood. I could not help suspecting that partial separation of the placenta had taken place at an early period of the labour—perhaps before the child was delivered, all the placenta was detached. I thought so, and this would account for the fœtus being dead, as well as for the quantity of blood contained in the uterus. The patient having been supplied with tea, milk, and brandy, from the time of

my arrival, rallied quickly after delivery.—This I regard as a distinct case of hæmorrhage into the uterus, owing to separation of the placenta, partial or complete; the blood escaping into the uterus, mixed with some remaining liq. amnii, and this flowing so tinged as to be considered all blood—but on examining the stain on the sheet, the colourless state of the margin shewed it was liq. amnii mixed with blood.

Case 74.

Mrs. D——, Jan. 25, 1836; fifth pregnancy. I was present at her first and second labours, on account of syncope and flooding—in the third and fourth there was also some flooding, but she got over it without any very formidable symptoms. Always healthy living children. This labour had not gone on long when Mr. S—— arrived—he found an immense flooding; and as os uteri was fully open, he ruptured the protruding membranes, and soon delivered with the assistance of the vectis—the child was in the right position and of full size. The placenta followed, and there was an appearance as if at one part it might have been detached prematurely, causing the hæmorrhage that preceded delivery. In all preceding labours the hæmorrhage had followed delivery. The child had been born an hour before I arrived. I found the uterus much distended with coagula, but firmly contracted. No formidable syncope supervened during two hours that I remained, and I left the patient with a fair prospect of doing well.—The patient recovered favourably.

Case 75.

Mrs. C——, æt. 25; miscarried 10 months ago at about third month of pregnancy—believed herself again advanced to nearly the full term, when on the evening of July 3rd, 1837, she had bearing down and great loss—sent for Mr. U——, who found little labour pain but great flooding, and os uteri scarcely open. Seeing great exhaustion from the loss, he ruptured the membranes to stop it. Patient had faintness, pallor, sickness, feeble pulse, jactitation; and I was sent for 13 miles. The loss had then abated; uterine pains came occasionally; no placenta at os uteri, into which I could just get my finger. Mr. U—— thought he felt the head of a dead fœtus, and that his finger en-

tered it, but it entered *in anum*, the breech presenting. With so great exhaustion, and to prevent further loss, delivery was desirable. Mr. U—— found a foot presently, but when he pulled, the limb separated at the hip joint, the fœtus being young, dead, and semi-putrid. A second leg did the same. A hook was introduced, but it broke through. I took charge of the delivery, and brought away the spine; got both arms out of the uterus—(these Mr. U—— pulled upon, but they both separated at the scapula)—the head was only very slowly removed, and not until pierced with the blunt-hook, and much extracting force being used. It appeared that the ossa innominata, with adhering soft parts, had separated and were left behind; separated no doubt when the hook was first used by Mr. U——, the sacrum remaining with the spine. The placenta was shortly removed entire. The patient ceased to be sick, and no longer flooded, but was excessively low. We thought it right to make no further attempt. Intense head-achs; such increased sensibility of hearing, that the ticking of a watch could not be borne in the room two days after; but on the 8th, I found pulse under 100; light nutriment retained; abdomen bearing pressure; no particular pain; so I thought favourably of the prospect. On the 21st July, I learnt that the patient was convalescent; and no pelvic portion had passed from the uterus, nor were there any signs of any remaining.

I suspect the placenta separating and giving rise to hæmorrhage into the uterus, was here the cause of the child's death; and that bleeding had been going on internally between the uterus and membranes some time before the outward loss. Large masses of dark coagula stuffed the placenta.

Case 76.

In the beginning of December, 1837, I was sent for by Mr. S—— to a Mrs. H——, æt. 42. No child for 11 years past, and now at about the full term. After some sudden uneasiness in the back, there was a vast gush of blood per vaginam, followed by faintness, tossing, and failure of pulse—these symptoms had subsided before I arrived. I found os uteri just open—very rigid—little hæmorrhage now going on—head presenting. I saw no other course than to wait; regarding it, as the placenta was not at os uteri, to be a partial separation of the placenta, but

cause of it unknown. Labour pains came on, and in eight hours from my being summoned, a dead male child was born. On examining the placenta, half of it was filled with dark coagula, quite different in appearance from the other half; leading me to believe that half the placenta had been detached, so as to cause the hæmorrhage, and perhaps also the death of the child. The woman recovered.

CASE 77.

Mrs. S——, æt. 44; her 15th pregnancy. In each preceding labour there had been hæmorrhage, and Mr. S—— informs me, that he almost uniformly expedited delivery by forceps or vectis on that account. She was arrived at the full term. Mr. S—— saw her at 9 a. m. Sept. 29, 1838, on account of some indications of approaching labour, but left her. At 10 she had a fainting fit, but recovered soon; got much better, and was cheerful and tolerably well between 12 and 1—then labour came on with loss; and although Mr. S—— had before satisfied himself that the placenta was not presenting, such were the symptoms of loss and fainting, that Mr. J——, who was with Mr. S——, delivered by turning—the child was dead. The placenta came with the child, and quarts of coagula. Delivery was quite over about two o'clock; and although no excessive loss continued, the patient was faint—pulse sunk—tossing about—and I was called at the last extremity, at four o'clock—pulse then seldom perceptible—a thin coloured loss going on—body well bandaged and supported. There had been a few uterine pains since delivery—doors open—cold cloths used—wine had been freely given. The patient expired in half an hour, not I believe from continuance of any loss after my arrival, but from the effects of the loss already sustained.—I interpret the case to be a partial separation of the placenta in the morning—consequent hæmorrhage into the uterus—death of the fœtus—and syncope with fatal result, from the hæmorrhage into the uterus.

At the late period of my being summoned, the only treatment was by stimuli, supporting the temperature of the body, &c. &c. Open windows, cold air, and refrigerant lotions were then inapplicable.

Internal hæmorrhage from premature separation (partial or complete) of placenta, sometimes proves more dangerous than

hæmorrhage from placenta prævia—it is more insidious—less easily, less promptly, detected. When strongly suspected or satisfactorily inferred, it is less amenable to active treatment; indeed, until labour has begun, until the os uteri is in some degree open, there is no active operative treatment for relief. Without knowing, and without taking the trouble to refer to what systematic writers say, I may observe, that there is hæmorrhage—1, internal into the uterus, from partial or complete separation of placenta—it may precede labour or attend it—result from violence, or be called (when we know not the cause) spontaneous. 2, from placenta prævia. 3, after labour, before the placenta is expelled. 4, after the expulsion of the placenta.

In a plethoric patient, or in any patient indeed, whilst there is a warm skin, force of circulation, a coloured countenance; and in the absence of all these, so long as loss is actually going on so as to constitute active hæmorrhagy, cold air, open windows, cold lotions, and such-like means are allowable. But the time arrives when, the loss having ceased, and distressing syncope remains as a consequence, you must rely upon stimuli, gradual application of warmth, and such means; and delaying to have recourse to these discriminately, adhering too long to the opposite method, as if there were no other, and as if the method were not to be varied to the stage, period, condition, circumstances of the case, is no doubt the source of many fatal terminations of puerperal menorrhagia.

Case 78.

Mrs. W——. On Sunday, 5th of August, being near eight months gone in pregnancy, she had, when recumbent, a sudden loss of several ounces of florid blood; but went on well afterwards until the 14th, when, awaking at two in the morning, she again lost very suddenly a pint of florid blood, and continued to lose a little until I was called at eight o'clock. Again she had a loss of some ounces of blood. There were frequent calls to pass water, and when engaged for this purpose, the loss came.—I examined about 10 a.m.; found external parts very relaxed—os uteri dilated to size of a crown piece—head of child to be felt through the membranes, but no placenta over os uteri. I believed the placenta to be near the margin of the os uteri, on the

side towards the bladder. The patient was pale from loss of blood. I named puncturing the membranes and letting off liq. amnii, as the usual practice where the placenta is not over the os; but I feared in this case, that if the head of the child descended into the pelvis, it would not be practicable to deliver quickly, should it become requisite on account of fainting and internal loss. So at one o'clock p. m. I ruptured the membranes, and proceeded to deliver by turning, which I effected in about an hour. The child was born alive. I was sometime before I divided the cord, waiting till the child breathed well, as there was pulsation in the cord. There was a large loss now, and I was obliged to introduce my hand to remove the placenta, part of which still adhered to the anterior part of the uterus. Some faintness ensued, and I gave a little wine and water. The uterus was, however, contracted—could be felt as a ball above the pubes. The abdomen was tightly supported by a bandage—only a little oozing continued on the napkins; but, delivery having been completed at two, there was great faintness at three—relieved by stimuli—but it recurred—more stimuli given—still, though only slight oozing, faintness could not be kept off, and at six o'clock the syncope was so great, that the pulse could not be felt for half an hour, though much brandy had been given, with milk and gruel, and retained by the stomach. I despaired, and really continued to give brandy, gruel, jelly, &c., with a view to persevere to the utmost, and keep the patient alive a little longer, as she was conscious, and expected the arrival of her sister soon. She was still in the same state at 9 p. m. I used cold water and napkins to pubes, abdomen, &c. The patient expressed comfort. I put ice into the uterus and vagina. Throughout the night such a degree of syncope was present, that I apprehended death every quarter of an hour—was always at the bedside—could often not feel pulse at all—once or twice only was there sickness—and not before six in the morning, after 15 hours perseverance, a pint and quarter of brandy, besides sherry, given, did the patient rally. By 8 o'clock the pulse were so steady, that I left her. For the last few hours before leaving, I gave a wineglass of milk gruel, with brandy, every half hour; before that, every ¼ or ⅓ of an hour. After this, the patient, though dreadfully weak, went on as favourably as could be hoped to a slow recovery.

Case 79.

Mrs. R——, æt. 42, mother of several children; healthy strong woman. In labour at full term; had profuse flooding before her surgeon arrived. Placenta not at os uteri. He ruptured the membrances, and let off the waters—the labour advanced rapidly without more flooding, and the child was just born when I arrived. The placenta was soon away, and all terminated well.

Remarks.

It is a most fortunate circumstance, both for patient and accoucheur, that artificial aid to any thing more than a slight extent is seldom required in Midwifery; so that those practitioners who are not engaged in consultation practice, are not very often called upon to witness cases of great difficulty. This is the bright side of the question; but when difficulties do occur, they are of no ordinary kind; they demand the greatest judgment, tact, and experience; and woe be to that practitioner, who, from long immunity from dangerous cases, is led to consider the practice of midwifery so easy and straight-forward, that he fails to qualify himself by diligent study for such emergencies as may one day or another occur to him. All the manipulations required to be practised by the accoucheur demand caution and gentleness; this without exception. But they do not all require rapidity of execution; indeed in many instances, particularly with reference to instruments, a certain degree of slowness is preferable, in order to imitate Nature, so excellent a guide in most matters of the kind. But there are some cases in which delay is dangerous, even fatal; where every thing depends upon the correct judgment of the accoucheur being promptly and fearlessly put in action; and the prompt determination of what is necessary to be done, unhesitatingly followed by its performance, is never more required than in what are termed *Placenta cases*. The

following cases are arranged under the four separate heads of *Placenta prævia; retained Placenta; adherent Placenta;* and *previous separation of the Placenta.*

Of *Placenta Prævia,* ten cases are reported, in eight of which turning was resorted to. Two mothers died.—One other case was a footling; and in another (premature, but not stated how far advanced in pregnancy), the head passed in its natural position and placenta with it. Both the mothers lived. Eight of the children are reported stillborn, but the other two are not mentioned as being so, and may therefore have been saved.

There are three cases of *Retained* and five of *Adherent Placenta*—of the former, one mother and all the children died—of the latter, all the mothers and four of the children were saved.*

Previous separation is a term employed by Mr. Crosse, I believe exclusively, to denote that partial separation of the placenta which gives rise to hæmorrhage before delivery, the placenta itself not being at the os uteri; or, in other words, to *accidental* hæmorrhage. In this last division there are nine cases, and their histories point out the danger and difficulty that may occur in *previous separation* of the placenta, particularly when the hæmorrhage is *intra-uterine,* without making its appearance externally to warn the accoucheur of the danger he has to encounter. The practice was, in general, to rupture the membranes; and in seven of the cases the mother was saved.

* From this it would appear that there is more danger to the child in *retained* than in *adherent* placenta; not, however, merely because the placenta is retained, for that is not necessarily dangerous to the child; but because it may have been *separated* from its connection with the uterus previous to the birth of the child, and thus have occasioned its death by interrupting the vascular communication between mother and placenta. In *adherent* placenta this communication is sure to be kept up until after the child has been placed in circumstances no longer to require it.—EDITOR.

In two, in one of which delivery was effected by turning, the mothers died; and in six the child was still-born, it not being stated in the seventh whether the child was alive or not.—Mr. Crosse has made some useful observations on this subject, but I prefer to leave them in their original situation; namely, appended to the cases which appeared to call them forth.

From this brief recapitulation it will be clearly seen, it is not without reason that accoucheurs, especially juniors, are in dread of placenta cases. I can scarcely imagine the possibility of any practitioner, *however much experienced*, being unmoved and without apprehension when he meets with *previous separation;* or *placenta prævia*; how then can it be expected that those of less experience should meet them without fear? Yet there is no description of case in which calmness and promptitude of action are more imperatively demanded; calmness, in order to form a proper decision, and to afford the patient an assurance that she is in the hands of a person not seemingly bewildered or frightened; and promptitude of action, to snatch her from the jaws of death. When a subject of this nature is duly explained and represented in its true colours, is it possible that any person can venture to undertake the responsible duties of an accoucheur without exerting all the energies of his mind, and the best feelings of his nature, to render himself fit to cope with the difficulties of his position? If he can, depend upon it there will come a time, if he chance to be employed, when his want of knowledge will bring upon him sad reproach; and his days may be embittered by the reflection that his presumption has led him into an error, fatal to an individual who had a right to expect due qualification in one who professed to be qualified.

It will be proper, however, to observe, when speak-

ing of the dangerous nature of placenta cases for the purpose of representing to junior practitioners the necessity for embracing every opportunity of gaining knowledge on the subject, that tables formed from consultation cases do not represent a correct statistical account of the proportion of severe cases, and that the results obtained from general practice are of a more satisfactory nature.

The subject of placenta prævia has of late been brought prominently before the profession, with reference to a plan of treatment advocated by Dr. Simpson and others, namely, the separating and bringing away the placenta before the child. Of course under this treatment, the life of the child must be sacrificed, and so it very often is when turning is employed, *but not always.*—Without entering into much discussion upon the subject, I would briefly state the views which I have been led to adopt, after due consideration of the method proposed, and the arguments by which it is supported.

In placenta prævia, the afterbirth may be placed immediately over the os uteri, so that its centre corresponds, or nearly so, with the os internum; or a larger or smaller portion of its substance may be in that situation, the chief of its bulk being fixed to the neighbouring part of the womb. In either case, hæmorrhage must *unavoidably* take place, when the os uteri dilates at the commencement of labour; and, generally speaking, artificial means of delivery will be required to ensure safety to the woman. Now it is an undoubted fact, that many children's lives have been saved where placenta presentations have occurred; and it cannot, therefore, be right to resort to a mode of treatment, *in every case,* which must necessarily destroy the child.—The two plans of proceeding in placenta prævia cases are—1. To pass the hand through or by the side of the placenta, turn and deliver.

2. To detach the whole of the placenta, and allow it to pass away before the child; the child being turned or not according to the part presenting; attention being paid to the same rules that guide us when the placenta is not in the way. In the former method the child *may* be saved; in the latter it *must* be sacrificed. What then is to decide between these different procedures? How are we to determine which to adopt?

When the placenta lies with its centre over the os uteri, or when it is partially protruded into the vagina, and the hæmorrhage is great, it is more than probable the child will perish before delivery by turning can be effected; and since the more simple procedure of detaching the whole of the placenta from its connexion with the uterus, is probably attended with less risk to the mother, it would seem to be the preferable mode of putting an end to the danger from hæmorrhage. When part of the placenta is attached to the uterus and part separated, the uterine arteries continue to supply the placenta with blood, which escapes from its separated surface, giving rise to fearful hæmorrhage; but when it is *wholly* detached, it no longer receives blood from the mother; that portion of the womb from which the uterine arteries have passed to supply it, contracts sufficiently to close them, and the hæmorrhage is stopped. When, therefore, the hæmorrhage has been so profuse as to lead to the opinion that the child must have died; and the body of the placenta lies over the os uteri, or is partially projecting into the vagina, I should not hesitate to proceed, upon the plan recommended by Dr. Simpson and others, to detach entirely the placenta from the uterus. On the other hand, when the placenta is so situated that only an edge, or small portion of it, lies over the os internum, the hæmorrhage may not at first be sufficient necessarily to

destroy the child; and by passing the hand into the uterus and turning, we may have the satisfaction not only of saving the mother from the effects of hæmorrhage, but also of preserving the life of the child. Therefore, in cases where the hæmorrhage has not been very alarming, and but a small portion of the placenta is situated over the mouth of the womb, we should resort to the latter method of delivery for the sake of the chance of saving the child.

It does not, happily, fall to the lot of any individual practitioner, unless attached to a public institution, or engaged in extensive consultation practice, to meet with a sufficient number of those fearful cases to constitute him much of an authority for the rule of practice to be adopted; I do not aspire to this eminence, or consider myself at all competent to dictate to others upon the subject; but I yield to no one in my desire to ascertain the most effectual method of treatment; and the result of my earnest consideration of what has been advanced in favour of both the above methods is, that I am disposed to be guided in my own practice by the regulations I have now ventured to recommend.

CHAPTER VIII.

INJURIES TO SOFT PARTS.

Lacerated Os Uteri.

Case 80.

August 30, 1827. The patient 44 years old. In her several former labours had long continuance of pains, but always regular and good—began to groan well the preceding evening; at two in the morning the membranes protruded, and were ruptured by a surgeon, who afterwards found os uteri very thick; and using his finger, he tore it at one part, so that the end of his finger entered the substance of the neck of the uterus. Violent pains continuing without progress for four hours, I was called—it seemed a case in which the state of the os uteri presented all the difficulty to delivery—it was swollen and 1½ or 2 inches thick on the side next the pubes; on the right side the edge of the os uteri was lacerated, and my finger went into the opening. The pelvis was sufficiently large—the child's head not impacted in it or fixed at all, but driven down at each pain and rising up afterwards—pains violent and forcing. In such a state of os uteri, I did not wish to use instruments, so I waited five hours, violent pains continuing all the while. There was very little change; the woman impatient and getting exhausted. By introducing my whole hand, I could feel an ear; so I applied the forceps, and after a few pains, effected the delivery of a fair sized boy, whom I revived from the still state he was born in, and left him well.—The membranes should not have been ruptured, and the os uteri had been meddled with too much.

Ruptured Uterus.

Case 81.

A pauper in St. Martin's at Oak, æt. 38; had nine children before; generally difficult times; but two last born without midwife calling further assistance. On Sunday and Monday had occasional pains, but rather called them cramp than profitable labour pains. On this day (Tuesday, 12th August), the midwife present from early in the morning, but strong pains not reported; they "broke off." Uterus not much dilated till mid-day. In the afternoon Mr. D—— was called in. Patient with extremities cold as marble; pulse scarcely perceptible—no pains. Abdomen very tender to touch, and child to be felt very distinctly, as if not enveloped by uterus. At eight o'clock in the evening, Mr. D—— sent for me. There had been no vomiting, and sp. ammon. and brandy and water, given by Mr. D——, had been retained. This absence of vomiting puzzled us, or else rupture of uterus must have been suspected. I found symptoms above detailed. Patient sensible and replying quickly to questions—pulse perceptible—extremities cold; body very tender even to the slightest touch—limbs and buttock of child to be felt through the parietes of the abdomen so distinctly, that I said the uterus enveloping it could not be ⅛ inc. thick. It was clear there could be no chance for the woman but by delivery effected in the easiest way. The head, in an ill-shaped pelvis, did not admit of an ear being felt; it was opened, and Mr. D—— removed the fœtus (which had not been felt to move since yesterday, and no doubt had been dead some time). During the extraction, the patient at first said she felt labour pain, and assisted by muscular efforts of abdomen; but sunk, in spite of brandy, which she could no longer swallow, and was dead just as the fœtus was fully removed. The placenta came with the fœtus, and on introducing the hand afterwards, the uterus was found to be ruptured several inches at its posterior part, the hand escaping from its cavity, and passing amongst the bowels. I apprehend the limbs and body of the child had escaped through the slit, and the head remained in the uterus; which will account for the latter resting at the brim of the pelvis, and not retiring so much as is usually found.

taken in labour March 5, 1829. Attended by a midwife who only found the labour tedious, but no uncommon difficulty or delay, and consequently conducted the whole process herself.—Labour lasted altogether about 24 hours, and twins were born, which the midwife thought were eight months children; but it is probable they were as near the full period as twins commonly are. Mr. B—— was summoned to her on the ninth day after delivery, on account of retention of urine (for which the catheter was twice used, and not afterwards required), found the private parts very much swoln, and sloughing had commenced, which rapidly extended, carrying away all the external and internal labia and lining of entrance into vagina, &c., and the patient was brought to a most desperate condition—but by great care and generous support, she struggled successfully with the mischief—the sloughs separated, the surface assumed an active state, and in five months all the sore places had healed.

A few weeks after this, Mr. B—— sent this patient to me, on account of her suffering so much pain for a few days every three or four months, in the back, rectum, and vagina, with bearing down, on account of the menstrual period, though no menstrual discharge took place. I found the labia gone, as well as the perineum, and entrance into the vagina; a firm cicatrix remaining, which shewed how great had been the extent of the sloughing, for the cicatrix reached on each side to the tuberosity of the ischia. In the course of healing, the vagina had become obliterated, so that the finger introduced into the vagina was stopt at from 1½ to 2 inches, when it formed a cul-de-sac. I entertained no doubt of a portion of the vagina existing above the cicatrix, into which the menstrual fluid escaped and was detained; giving rise to the occasional attacks of pain. I felt a bulging, answering to the upper part of the vagina, with my finger *in ano;* but not distinctly enough to be satisfied the menstrual fluid was accumulated there. I advised waiting for the case being more evident, in reference to means of relief. The pains recurred at shorter intervals, keeping off only a week or ten days, and then retnrning, to her great distress. On the 4th November, I went to the house of the patient with Mr. B——, to take some decisive steps for relieving her; she now holds her water pretty well, except when she walks much, and then a little

escapes. With the finger in ano, I now felt a prominence, two inches from the verge of anus, which indicated fluid contained, I could not doubt, in the upper part of the vagina; keeping my left fore finger in this situation (the patient on her back, and knees drawn up), I took a small flat trocar and passed it to the obstructing cicatrix in the vagina, which I pierced, directing the instrument into the space occupied by the fluid which I could detect with the finger *in ano*. I had previously introduced the catheter into the bladder to be sure it was free from urine. Having pushed the trocar to the depth I thought fit, I left the canula, withdrew the trocar, and a little dark clotted blood came through the former, convincing me I was right. I then withdrew the canula, and introduced through the opening thus effected, a director, which passed its whole length, 5½ inches, proving how large a cavity I had opened. Withdrawing the director an inch or two, keeping it still in the opening, I turned its groove to the right ischium of the patient, passed a common scalpel along it, and made an incision through the obstructing cicatrix in that direction. A tea-spoonful of dark blood escaped. Now I could get the tip of left fore finger into the opening, and on this I introduced a probe-pointed curved bistoury, and made an incision in the opposite direction transversely, that is to the left ischium—then the finger was freely admitted into a large cavity, the dilated upper part of the vagina; and slowly, by the patient's straining, getting into sitting, and afterwards, into standing posture, we got away eight ounces of dark semi-fluid material, in colour like coagulated venous blood, but in consistence ropy, resembling very much the meconium of the fœtus: no doubt the mucous secretion mixed with the menstrual fluid gave in part this consistence to it. The cavity was so large that I could not feel the os uteri; but Mr. B——, with a longer finger, said he could. I advised a bougie, the size of the finger, besmeared with mild ointment, to be once or twice daily introduced to prevent obliteration of the passage to the uterus, as the parts I had cut should become cicatrised.

I did not again visit this patient; but on the 13th February, 1830, she came into the Hospital under my care, when I learnt the following particulars of her history since I last saw her. For a fortnight after the operation, she retained her urine; but since

that, it has dribbled constantly, She has never had any menstrual appearance, save what flowed within a day or two after the operation; and after a month, she began to feel the uterine pains as before, and has continued to suffer in that way every two or three weeks in an increasing degree. The bougie had been introduced for several weeks, at short intervals, either by Mr. B—— or one of his pupils.

On admission into the Hospital, I find the urine escapes through an opening of the urethra into the vagina ¾ inch above the external orifice of the urethra; and I can only conjecture as to the formation of this opening, that by the rough use of the bougie the old cicatrices were injured and destroyed so as to open the urethra; it could not by any possibility have been injured by me with the trocar or scalpel. The finger now is freely admitted into the vagina, and the swelling, big as a goose's egg, in which the menstrual fluid is retained, lies at the upper part of the vagina and towards the rectum, being also felt prominent in the rectum; it does not seem to me to be as formerly, when there was the greatest difficulty in getting into the vagina, which indeed was quite shut up. I really conjecture now that the menstrual fluid is retained in the cavity of the uterus, distending it; and that the os uteri has closed by cicatrices, the bougie when used after the last operation being passed in a wrong direction, and not into the uterus, keeping it open. At all events, by cicatrization, the opening has closed by which the menstrual fluid was discharged, and the fluid has for above three months been retained. On the 23rd February, I punctured the cavity at the upper and posterior part of the vagina, and with a probe-pointed bistoury and director enlarged the opening a little to each side, so as to be able to get in my fore finger; some ropy menstrual fluid escaped as before, and I left the patient to herself that the fluid might escape gradually; 2½ pints of menstrual fluid, resembling treacle, passed away in the next 24 hours.

25th. There was a cold chill yesterday morning; pain in the body since; frequent purging; pulse 120; the countenance pallid; features sharp; body tender on pressure about the navel; she lies upon her side, and has been repeatedly sick. Ordered effervescing draught; a large blister; cal. and opium at night. Pulse were 140 in the afternoon, and at night, two hours after taking the pill, she was sleeping.

[illegible]

covering about the pelvis and lower part of the abdomen was very vascular; less so in upper parts of abdomen. The uterus was

the fleshy hymen pushed forward by a large collection of fluid behind, and was occasionally protruded almost beyond the external labia. I had no doubt all her symptoms depended upon the retention of menstrual fluid; and on puncturing the centre of the projecting tumor with a lancet, and introducing a director, I let off a large quantity of dark bloody fluid. This continued to flow so that I could not conveniently see to enlarge the opening without an assistant; so I introduced a bit of lint into the wound I had made, and promised in two days to see her again, having enjoined rest and fluid diet. When I saw her two days after, she told me the lint had come away when she was passing her water, that the dark fluid had continued to flow all night, and that she now felt quite well. On examining with a view to further proceeding, I found the opening quite closed, at least so I supposed, as I could not find it to introduce even a probe; the swelling was entirely gone, and the hymen was flaccid, with a reticulated appearance upon its anterior surface. Under these circumstances I advised no further treatment at present, but requested her to let me know when she again felt symptoms of being unwell. A few weeks afterwards she sent to me as I had requested, because she was unwell, and I found that she was menstruating freely. Another month, and the same thing happened, but I could not see where the menstrual fluid escaped, nor could I introduce a probe anywhere through the hymen. She was so well satisfied with her perfect feeling of health in all respects, that nothing more was attempted, and she went on menstruating both regularly and in proper quantity. But at length she wished to be "like other women;" indeed she had a lover, and wished to undergo another operation. The hymen was divided, and a rectum bougie introduced for some time afterwards; there was some inflammation, and considerable discharge; but at length the parts healed, and the last time I examined her, it would have been difficult to have ascertained that any previous malformation had existed, the entrance to the vagina not being much narrower than usual in virgins of her age.

This is an instance of the imperforate hymen being punctured without ill consequences; and if Langenbec be right in attributing the tendency to peritoneal inflammation to long retention of the menses, perhaps it may raise the question whether in such cases it is not better to make a simple puncture to evacuate slowly the retained fluid, and then leave the patient to recover entirely from the effect of retention of the menses before any other means are taken to open fully the passage into the vagina. In this case the girl did not suffer an hour's inconvenience from the first puncture, and then went on menstruating perfectly for many months; and in all probability would have continued to do so, although I could not discover the opening through which the fluid escaped. Had she been content to lead a single life, she might have remained as she was in perfect health. When the further operative proceeding was effected, she had been so long cured of her troublesome symptoms, that *no inflammatory tendency from retention of menses could then have existed*, and she perfectly recovered.—Ed.

large enough to contain several ounces of fluid. There was no serum or lymph effused into the sub-peritoneal cellular tissue, only on the peritoneal surfaces.

CASE 84.

Mrs. C——, æt. 34; first pregnancy. Mr. S—— summoned on account of labour on Monday morning; kept in the house during a slow progress of labour till Saturday afternoon; then delivered, with forceps, a child which had been for 7 or 10 days dead. The face was towards the pubes. I was called the next Tuesday evening, on account of fever and pain in the body; it was stated the urine had dribbled away, and the fôul discharge convinced me there was sloughing of the vagina. On ocular inspection, I found the perineum slit to the verge of the anus; the margins of the slit sphacelated, as well as the interior of the vagina as deep as I could see, including the anterior part next the urethra. I drew off three pints of urine, which gave relief; there was no peritoneal inflammation; pulse 110. I directed the catheter to be used night and morning; chloride of lime poultice to the perineum. The night passed quietly, but next afternoon the patient was ravingly insane, talking wildly, often indecently. On the Friday, six days after labour, I attended with Mr. D——; she was in the same state of raving; could just be kept in bed; no bleeding to be practised; pulse 120; tongue furred and moist; when a motion passed, she allowed it to pass in the bed without giving notice; urine not passed, but drawn off with the catheter; it was agreed to soothe, give laxatives; opiate at night (4 grs. cal. gr. i op.) and liq. opii. sed. m.xxv. On the 1st of March, I found the patient tranquil, rather in a stupor; seldom violent; tongue moist, not much furred; catheter still used, urine rather scanty; no motion for three days; to be purged and have a glyster. The sloughs of the vagina and labia have all separated, leaving a healthy granulating surface; chloride lotion; syringing; dry lint to the vagina.

In the beginning of April the patient was so much recovered in mind as to walk out and see her friends.

This case included a great many points:—1st. A consultation would have been proper in so tedious a case, to determine on the use of the forceps; it might perhaps have been ascertained that

the child was dead, and then, the head being opened, the mother would have been spared suffering, injury, and possibly all other serious complications of the case. Certainly had it been known the child was dead (and the liq. amnii, and separation of cuticle from scalp would shew it), the head should have been opened.

2nd. Was the sloughing occasioned by the head of the child long pressing on an unyielding perineum, or by the use of the forceps? I fear the laceration was from the forceps, and suspect the sloughing was also; for it does not seem that the child laid low with the head on the perineum, for the ear could not be felt even when the forceps were used.

3rd. There being no primary peritonitis, though much inflammation of soft parts, of perineum, vagina, cellular tissue of pelvis, &c., I hoped for recovery, and also that the urethra was not opened, and that the bladder might recover its power.

4th The insanity, though singly rarely ending fatally (Mr. D—— never knew it, nor I except once), yet complicated here with an even dangerous state of sloughing and lacerated vagina, must be regarded very dangerous.

Case 85.

Mrs. F——, æt. 40; first labour; attended by Mr. ——, who after 24 hours of regular severe pains, and when os uteri was considerably dilated, ruptured the membranes; then waited 24 hours more, when, by use of vectis first, and then of forceps, he effected delivery; the child was dead, and had no doubt been so some time. On the evening of same day, vomiting occurred. I was called in consultation on the morning of April 25, I think three days after delivery; the patient with rapid pulse, lying on her side; and though the body was rather prominent, I did not detect peritoneal inflammation; tongue parched and rather brown; occasional vomiting. Examining the private parts, I found perineum lacerated for about an inch, but not to the extent of reaching the sphincter ani. The whole lining of internal labia and of vagina, as far as I could inspect, was sloughed and black from mortification; fœtid smell issued. I confess that I consider the child's head pressing so long under strong pains, caused the sloughing, or may be supposed to have caused it rather than the use of the forceps, The urine had dribbled, and I suggested the

catheter. A pint of urine was drawn off, and the catheter afterwards regularly used. I suggested also syringing the vagina with chloride of lime lotion. Lavements to be used rather than purges, particularly as the stomach was so irritable. There was no room for any reducing treatment; the object was, if possible, to quiet the stomach, and get down bland nourishment. Opiates I reserved for night, but the patient could get no sleep; a poultice to the mortified parts.

April 26th. At night Mr. —— reported to me that the patient's tongue was more brown and parched; some pain in abdomen, which was getting more tympanitic; pulse 140. I discountenanced a blister in this stage and with such symptoms present; believing that if it acted at all, death would be expedited.—This woman died about two days after I saw her.

Ruptured Perineum.

Case 86.

About 11 p.m. on Sunday, 5th September, I was called by Mr. B—— to Lydia M——, aged 19, from whom I learnt that she began to groan (first pregnancy) on the morning of Saturday week previous, and was delivered at half-past four on the following Sunday morning by instruments. I found her lying on her right side; pulse 130; countenance uneasy; abdomen tender all over on pressure, particularly in the region of the uterus, and great pain complained of constantly, no doubt peritoneal inflammation; she had vomited recently. On examining ocularly I found the perineum had been lacerated centrally to the verge of the anus. One inch next the anus had reunited, the rest remaining slit and disunited. I knew this inch had been torn and reunited, because one edge was higher than the other, with an elevated granulating line upon one edge of the slit to the extent of the inch. I was careful not to break through it; a quantity of bloody and foul discharge escaped from the vagina; no sloughs; but the finger in the vagina gave me the sensation of rough jagged surfaces from which sloughs might have separated; the anterior perineum not slit. I ordered chloride poultice; use of catheter, as no water passed for 12 hours; a repetition of leeching to the number of 20—calomel and opium; poultice after leeches—blister.

Monday morning—pulse 120—countenance better—no vomiting—body easy since the leeching. At noon, fainting, cold extremities—clammy perspiration—difficult breathing. At five, I again saw her—better; pulse 120—pale clammy skin—no motion—purgatives—catheter morning and evening.

Case 87.

Mrs. T——, æt. 23; first labour, on Sunday, April 25th—pains for 12 hours, but the surgeon was present only an hour and half before a female child of proper moderate size was born; he supported the perineum, and delayed the birth, because the soft parts did not dilate fast enough. I was called on the 28th, on account of the perineum having been lacerated. I found it torn about an inch, up to the sphincter ani, and we put in two sutures to bring the wounded surfaces together, hoping they would unite. This lady was of fair complexion, and of such a relaxed fibre, that I deemed her a favourable subject for laceration of perineum.

Case 88.

Mrs. H——, æt. 25; first labour. Mr. W—— had left her, the labour for five or six hours going on slowly; and when, at the end of two hours, he arrived on a summons, the child's head was born, and the perineum ruptured. It was a few hours after labour in other respects was rightly terminated, that I saw the patient—found the perineum lacerated to the sphincter ani. I inserted one stitch, bringing the divided surfaces in contact; the injured parts were very thin, very flaccid, and readily pierced by the needle. Ten days afterwards, Mr. —— reported that the case was doing well.

Remarks.

The cases reported under this head are of fearful interest, inasmuch as the mischief they represent may, with care, be generally prevented; and if not prevented, an amount of misfortune is entailed upon the sufferer, which may make life no longer desirable, or else bring her existence more rapidly to a termination. The use

of instruments, and still more the *abuse* of instruments, is the most fertile source, probably, of some of the injuries exemplified by the foregoing cases; but it is as well to bear in mind also, that inflammation and sloughing of the vagina, together with the more remote effects of these diseases, sometimes arise from *long-continued pressure of the child's head* upon the soft parts, which might be prevented by instrumental aid. The judgment of the practitioner must guide him in his choice, when it happens unfortunately that the greater or the less evil is the only alternative. I have never met with any case of severe inflammation or laceration in consequence of labour, instrumental or natural, and have no desire to be much experienced in the matter; but if such occurrences be sometimes really unavoidable, let us at all events exert our utmost endeavours to avoid their being the consequence of our own ignorance or mismanagement. With respect to one of the accidents included in the present division, namely, inversio uteri, I have thought it better to omit it altogether; since, in the admirable treatise published by Mr. Crosse in the Transactions of the Provincial Association, there is a most ample and satisfactory elucidation of the subject, which no practitioner can study without deriving a proportionate degree of advantage.

CHAPTER IX.

CONCOMITANT DISEASES.

Measles.—Case 89.

Mrs. B——; third labour; attended by Mr. W——; child born on Sunday, January 25th. Healthy at the time of labour, and the labour easy, regular, quickly accomplished. Monday, going on well. Tuesday evening, some fever, supposed from breasts filling. Wednesday, well purged—still feverish. Thursday, some pain about uterus—rapid pulse—furred tongue—the symptoms got worse, and I was called in at ten on Thursday night, Mr. W—— supposing it a regular case of puerperal fever. I found the speech muffled, a sort of impediment in speech; countenance sunk and anxious. She scarcely knew people, and could not pronounce my name. There was some tenderness in the region of the uterus, but not over the rest of the abdomen—pulse very small, 120 or 130—tongue reddish and patulous—she had laid partly on her side, but chiefly on her back—no urine passed since she had a motion 10 hours ago, and on being drawn off with the catheter, it was found there were 6 or 7 oz. of dirty, like ditch, water—lochial discharge stopped—breasts flabby. To some of my enquiries she seemed not alive, and was about to draw up her chemise without reference to decency, not knowing what she did—breathing laborious, as if from langour of respiratory muscles—talked incoherently. She had coughed in the day, and complained of some soreness in the throat. The neck, arms, and thighs, as well as legs and body, were occupied by a red eruption in distinct small patches like measles, and we were assured she never before had measles. Nurse said this eruption appeared the day before, though she had not mentioned

it, nor had Mr. W—— seen it. I suspected it was measles, coming out imperfectly; abortive measles; and that her symptoms were owing to it. The case, from my first sight of it, seemed hopeless. Blister to lower part of abdomen—leeches to temples—cal. and opium, were the means advised to be pursued during the night.

At 8, Friday morning, patient had been comatose during chief of the night—pulse not perceptible in right wrist—just felt in left, and 140—tongue parched—body not tumid—use of catheter shewed not ℥ss of urine formed during the preceding night. The eruption still very evident—skin warm, but covered with perspiration, i. e. clammy, but not cold. It seemed hopeless, but wine and broth were ordered—sinapisms to feet—a stimulating mixture of ammonia and tr. card. c.

At 1 p.m. nothing taken—lies comatose. I roused her, and gave some wine and broth in equal quantities. In the evening she rallied a little, wine and broth having been repeatedly taken—could be roused and made to know people—knew her husband, who returned after an absence of several days—the eruption still very distinct on hips, thighs, and legs; and Dr. W—— concurred with me in saying it resembled measles above anything else, and might be regarded as abortive measles. She died in the course of the night—body not inspected.

I am inclined to regard this simply as measles occurring in childbed, and assuming this malignant form owing to some peculiar state of system; though at this time all females bear measles badly, and it may be always considered dangerous to childbed women. There were no petechiæ visible. The cough here was slight, not characteristic, and the eyelids not at all affected; but in measles which do not shew themselves by a proper eruption, all the usual signs are imperfectly exhibited.

Fever, with glandular swellings in the Throat.

Case 90.

Mrs. N——, when eight months gone, was seized with fever, great prostration of strength, swelled glands about the throat, and hysterical symptoms as if there was a ball in the throat. Mr. S——, in my absence, gave æther and tr. lavend. In the

course of the night, there were slight labour pains. Next day, pulse rapid and small—throat relaxed—equal prostration. The second night marked by stronger labour pains; and next day she was regularly in labour, detaining me in town. The uterus acted irregularly—pains feeble—os uteri nearly closing during a pain, and being open and easily dilatable when pain was absent. I gave three doses of ergot (15 grs. each), at intervals of an hour; and each dose was followed by violent and marked uterine contraction—still the child did not rapidly advance. I succeeded better by dilating the os uteri with my fingers; and in the evening of the same day, labour terminated well—a dead child born. I felt the body yielding and bearing pressure well before I left, and the uterus well contracted. Sleep was obtained in the night. Next morning greater feebleness—laboured breathing—rapid small pulse. I ordered strong broth. In the course of the day, the abdomen became tumid, though it bore pressure, and she lay on the side. She died before the following morning, 36 hours after labour was ended. The previous disease, to which the reducing effects of labour were super-added, led to death, and labour was not the primary acting cause of death in this instance. It may be doubted if peritoneal effusion took place; I am inclined to think not. We were prevented from inspecting the body. The swelling of the glands about the throat at the outset and their rapid subsiding, was very remarkable.

Convulsions.—Case 91.

A soldier's wife, æt. 29 years; first pregnancy. Sept. 27, 1826. For three or four previous days, she had violent vomiting, and it was supposed that gall stones caused it, as there was no purging. Her labour commenced this morning, and was preceded by a convulsion. Several convulsions occurred during the day, with occasional labour pains—she was blooded. In the evening I was called—then labour had advanced, and with forceps I readily effected delivery by one pain; which I was glad to do, as she was unconscious, with pulse 150, and there was reason to apprehend a return of convulsions (which might prove fatal), which had frequently come on throughout the day. She was dull till next morning, when she was doing well, having had no return

of convulsion—she knew nothing of what had transpired the preceding day. The fœtus had been dead some days.

CASE 92.

Mrs. S——, æt. 29; first pregnancy. Had giddiness and fulness of head a few days before labour, but refused to be blooded —a corpulent large woman. After being 24 hours in labour, and os uteri for three or four hours fully dilated, she became restless and unmanageable—out of bed and into bed—fell down in getting out of bed—had a severe convulsive fit, and on its going off, raved and required several persons to restrain her—a second convulsion came—she was bled freely, and I was sent for. On my arrival, she was quiet and rational—head so low that an ear could be felt—soft parts enough relaxed to make the use of forceps proper if required on other accounts; which, seeing her present state, with pulse small and 130, and fearing return of convulsion, I thought proper. I applied them readily, but it was above an hour before the child could be born. She was manageable and behaved well all this time—but, when the afterbirth had been removed a few minutes, a terrible convulsion came on, lasting for half an hour, with foaming, stertorous breathing, contorted eye-balls, contracted lips, leaden hue of countenance; and when she became more still, the pulse could just be felt—then to be told 150—cold clammy skin. A free dose of laudanum was given, and a cup of gruel. She came round in a few hours; and on my visiting her six hours after, she was recovered well—rational, though not recollecting what had happened, nor that I had been there. The weather was very hot when this case occurred—cold water used to the head, and every precaution adopted, needless to specify. I cut off an immense head of hair during the convulsion I witnessed. A more appalling case I never saw.

COMA.—CASE 93.

M— H—— had a child seven years ago; was again pregnant and six months gone, when, after head-ache and pain in the stomach, she had a fit, and I found her snoring as if in deep sleep—bleeding—leeching to temples—purging. She continued comatose, and next day the fœtus (female), with all its membranes entire was voided, without her making any exclamation

from uterine pain. Empl. lyttæ nuchæ, and mustard poultices to feet—left arm motionless—pulse very small—tongue parched, furred, black; but she began to be able to swallow. I gave bland nourishment, and a little stimulus; in 4 days she was sensible, could speak, and moved the left arm a little. She recovered the use of this arm and did well.

Convulsions.—Case 94.

Mrs. C——; first pregnancy; under difficulties and depressed spirits—under 30 years of age—labour began with a convulsion—eye-sight and sensibility lost—pupils greatly dilated. I was called in consultation—the os uteri was much dilated—delivery effected by forceps. Bleeding and blistering being freely practised, the convulsions ceased—eye-sight quite lost for several days, at length returned, and there was perfect recovery.

Case 95.

Mrs. S—— expected to be confined in the middle of May—was desponding—thought she should not do well—had suffered misfortunes which fell severely, being a genteel sensitive woman—took up religious opinions too seriously lately, and distressed herself with that most degrading of all perverted doctrines, the Millenium. In the beginning of May, got nervous and very apprehensive, which in a few days increased till she really was insane, talked loosely, and even immodestly—often thought labour was present, and sent for me many times, night or day; would have me examine, and urged me to complete labour, which really was not at all begun. By exclusion of all persons except proper attendants, by reasoning, by the return of her husband who aided in this, she got quiet, and after being a few days kept on her bed, she became composed—sat up on the 14th—quitted her bedroom on the 15th, and took tea with the family apparently well. At 4 a. m. on the 16th, the child was born with only a pain or two, and was crying before the messenger was sent for me; and when I arrived, the nurse had removed the placenta, and all was quiet. The patient spent the day well as to health, but would not believe she was confined till the child was brought and put to the breast—this was done twice in the day—regular after-pains occurred during the day, for which I gave an opiate. At 10 p.m.

I was told she had had a stoppage, lasting a few minutes, and just gone off. I found her a little dull and incorrect, but as to pulse and countenance, well—urine passed—regular soil on napkins.

At 6 a. m. on the 17th, I was called to her, and told a stoppage had thrice come on since I last saw her. I found her dull, but answering questions, and knowing those about her. Soon after, a regular severe convulsion came on, with twitching of muscles of face, purple countenance, the tongue bitten, limbs rigid, &c. These fits returned every half hour—then more and more frequently; at last every ten minutes; and she died at six in the evening, 38 hours after labour. In consultation with Dr. E—— and Mr. D——, bleeding was not thought proper—mustard poultices to ankles—shaving the head, and spirit lotion—a glyster—blister to calf of legs—were tried in the first few hours after regular convulsions were recognized.—Post mortem inspection was not permitted.

Case 96.

Mrs. R——; labour natural—regular—and all prosperous under strict management and precautions, until the 6th day, when a severe convulsion fit came on, lasting 10 or 20 minutes—bleeding—active purging—low diet—and all well till 10th day; and then, when sleeping in the morning, a fit came on as before, and returned every half hour for 10 or 12 times, till, in the intervals of the convulsions, the patient lay comatose, pupils dilated, urine passing involuntarily—tongue severely bitten; bleeding, leeches to temples—5 gr. doses of calomel every three hours—hair removed—cold lotion to head—blister to nape of neck—mustard poultices to calf of legs. Two hours elapsed between the 11th and 12th fit; 4½ hours before another came—then no relapse—but sensibility gradually returned, and on the 14th day there was every promise of perfect recovery.

Note.—The 2nd attack of convulsions, after four days interval, came on under every precaution as to low diet, open bowels, and quietude. Still I attribute both attacks to fulness of vessels of the head, conjoined with particular nervous susceptibility of the puerperal state.

After this, insanity came on, unattended by convulsion; and

continued a week or two, subsiding by 3rd of November, when a slight menstrual appearance took place.

Case 97.

Mrs. H——, æt. 22 ; first pregnancy ; about the full term ; was seized with a convulsive fit, which returned several times before I saw her. Free bleeding from the arm—leeches to the temples—blister to nape of neck—sinapisms to feet—labour was scarcely begun, when we consulted after several severe fits ; and I was not for then attempting to turn in a first case, with such a state of uterus. When 12 fits had occurred in about eight hours, they ceased—in three hours more, labour was so advanced that I applied forceps, and Mr. G—— delivered—the child dead. The fit did not recur, but pulse, next day, 160—third day, 120. She ultimately, though slowly, recovered.

Case 98.

Mrs. K——, æt. 20 ; first pregnancy ; arrived at full term ; she had numerous convulsive fits in early stage of labour before I was called to meet Mr. —— and Mr. ——. I found os uteri considerably dilated, and head so low, that I thought turning impracticable. Mr. —— thought otherwise, made the attempt to turn, but failed. I also attempted to turn without success ; and in such attempt, ascertained that the funis had suffered compression, and had no pulsation—we therefore did not hesitate to open the child's head, and thus expedited delivery. Convulsive fits returned after delivery, in spite of blisters, &c. (bleeding had been early freely adopted). The patient was comatose for 48 hours ; then became sensible. Committed error in diet, and in two days more was raving with insanity. In a fortnight she had perfectly recovered.

Case 99.

Mrs. C——, of L——, æt. 25 ; first pregnancy. After 12 hours of uterine pain, terminated her labour favourably in all respects, by the birth of a very large child, about midnight, on Sunday, the 20th of October. Her surgeon remained with her above two hours, and left her apparently quite well. She fell asleep and awoke at three o'clock on Monday morning, seized

with a strong convulsive fit. Mr. —— was soon in attendance, found her face very flushed (she was a tee-totaller, but a florid rather stout woman), and convulsions of the most severe kind, recurring in the worst form. He bled freely from the arm—convulsions returned at short intervals, leaving her sensible when they were off. Castor oil was given—mustard poultices to calf of each leg and soles of feet—at length the convulsions returned every three-quarters of an hour, leaving the patient quite insensible in the intervals. This was the state when I arrived at one o'clock p. m., ten hours after the convulsions commenced. I found a pallid countenance, small and most rapid pulse—a douche of cold water over the head shortened a convulsive attack. I ascertained the bladder was not distended—gruel injections with ℥ij. sp. tereb., were given and repeated. As we could get no ice, we had bladders of water cooled by solution of ammon. mur. and pot. nit. (*aa* ℥jv.) and applied to the head, the hair being cut off. I repeated leeches behind the ear, but thought no further bleeding from the arm admissible—repeated mustard poultices more effectually to the feet and instep—gave 5 grs. of calomel in dry powder put upon the tongue, more than once. Thus both Mr. —— and I were incessantly employed for three or four hours; convulsions (epileptic) returning every three-quarters of an hour. When I first arrived I hoped for recovery, calculating on the small proportion of such cases that prove fatal; but about four o'clock, the attacks became more frequent, every quarter of an hour, and I thought the patient must sink. But after a severe attack at half-past four, there was no repetition till half-past nine; a slight attack. Patient became a little sensible—took a teaspoonful or two of milk or gruel; and when I left at half-past six on Tuesday morning there had been no convulsion for nine hours, and although the pulse were very small and rapid, and the patient was scarcely sensible for two minutes at a time, I expected that without a return of convulsions she might recover.

26th.—The patient is doing favourably—the child is put to the breast; but she does not remember anything of her labour, nor subsequently during the many hours I was with her. There was perfect recovery; but the integuments and cellular substance of the calf of the legs sloughed from the sinapisms, causing great pain and trouble.

CASE 100.

In the latter end of March, 1841, Mr. B—— summoned me to a patient of low stature, æt. 39—delivered of twins; and five or six hours afterwards, severe convulsions came on—they had continued an hour or two before I was called, and were extreme. Mr. B—— had blooded the patient largely. I directed mustard poultices to the feet—calomel to be put on the tongue, as nothing could be swallowed. I left the patient soon, but learnt afterwards that when the mustard poultices began to act, the convulsions went off and the patient recovered. She had suffered much from great size and pressure under twins, and the lower limbs had been very ædematous. The placenta had separated properly. I should have observed, that the cessation of the convulsions occurred as soon as the bowels were relieved. I had omitted to order an injection, although it would have been very proper, particularly as the patient could not swallow medicine.

CASE 101.

Mrs. T——. Four or five nights before regular labour, she had spurious severe pains for several hours, and all went off.—Labour began about midnight, by rupture of the membranes under a very strong pain. I was immediately sent for, and remained to ascertain the gradual dilatation of os uteri under a natural presentation; and after pains had been strong and frequent ten hours, and when os uteri was fully dilated, and head low down, the patient complained of pain in the head, and required it to be held—during two following pains this occurred; and in the intervals, she talked incoherently—after the next pain, as violent a convulsive fit came on as I ever witnessed. I bled to 30 ounces, and it was removed. Slight twitchings of the face afterwards during pains—but no fit. In less than an hour I delivered with the forceps; but the perineum was, I believe, slit nearly to the anus. The child was stillborn, but revived after three-quarters of an hour's attention—it however died next day.

CASE 102.

Mrs. J. C——, æt. 42; mother of a large family; five children born in the last seven or eight years; was now seven months gone (although of thin habit and rather dyspeptic, still accus-

tomed for two years to take half a pint of porter thrice in a day), had taken porter with her lunch as usual on 2nd of November, when she was thrown into distress by a servant having robbed her. After this agitation, she complained of being faint, and took a glass of wine upon the porter—then great pain and oppression of stomach—a few convulsive twitchings of the limbs were observed—and some hours afterwards a violent convulsion came on, with coma and all the usual signs of puerperal convulsion.—A bleeding of 20 or 30 oz. was immediately adopted, and the convulsion subsided, leaving the patient apparently in a sleeping state, which went on for two or three hours—then she was roused, and attempting to take some drink, a second severe fit, like the first, came on—bleeding repeated to some 20 oz. and the fit subsided. I arrived at 8 a. m. Nov. 3rd. After second severe fit, patient remained three hours apparently asleep, comatose; but two convulsive attacks had occurred in the hour preceding my arrival, and in a few minutes I witnessed another, which lasted 10 or 15 minutes. The urine had passed unconsciously—although a glyster was tried, no motion had been obtained; and as the patient was unable to swallow, no further medical treatment had been adopted than has been already named, save rubbing lin. ammon. upon the epigastrium. The pupils were moveable, but the patient lay comatose, not quite insensible, for on examining *per vaginam* to ascertain the state of uterus (which I found giving no signs of labour, but just admitting the tip of my finger), I gave annoyance to the patient. The immediate treatment agreed on in consultation was, the hair to be cut short —24 leeches to temples; sinapisms to ankles—cal. ℈j. with gts. ij. ol. crot. to be put upon the tongue, which was chiefly swallowed. An enema of salts, senna, oil, and turpentine. Catheter to be used; it drew off half a pint of dark turbid urine.

I was four hours with the patient, and saw no repetition of convulsion. She was able at length to take a few tea-spoonfuls of bland liquid; and we agreed that a purging draught of salts and senna should be given, and repeated till the bowels were well relieved; from which, as the attack came on after a meal, we hoped to find great benefit. It was agreed before we parted, that leeches were to be applied to the labia pudend. in case of return of fit, and a blister to the region of the uterus imme-

diately. As to the prognosis, I thought the patient had a chance of recovery, and were the uterus emptied of its burthen, I considered that chance to be a fair one—but there was no indication of uterine contraction, and I could not regard it advisable to bring on premature labour artificially, particularly as the convulsions had not returned for several hours. I regarded this as a case of convulsion from plethora; and the habit of taking porter thrice a day would contribute to the arising of such a disease. Dr. C—— talked much about hysteria, and about epileptic fits, and was rather inclined to give antispasmodics—still he concurred in thinking the past bleedings proper.

Soon after, I received the following from Mr. C——: "After you left, I injected two pints of warm water into the rectum, and succeeded in getting into the stomach about ℥ij. mist. senn. c., and kept her quiet two hours; then had her laid into another bed while her own was making, during which time the medicine operated upon the bowels several times very copiously. She had a very tranquil night, slept four or five hours altogether, and is perfectly collected this morning; knows nothing of what has passed, not even that leeches had been applied; and, excepting swimming in her head, she makes no complaint. Pulse 90—rather feeble." In my reply, I observed that abstemious living and the avoidance of spirituous beverage, were the means to be used to avert as much as possible a relapse of this formidable disease, to which in a few weeks the occurrence of parturition must most strongly dispose the system.

Dec. 13th.—Mr. C—— wrote: "Mrs. C—— had some returns of headach, with some subsultus, for four or five days after you left her, which were subdued by leeches and antiphlogistic measures; and she was kept as quiet as possible till Tuesday morning, 11th inst., when by the most natural efforts, a fœtus of about six months' gestation was expelled, which had apparently died about three or four weeks previously.* She has had some headach since, but upon the whole is doing very well."

* Did the fœtus die during the violent convulsive attacks?

CASE 103.

Mrs. —— was delivered of twins in May, 1844. A feeble slender woman; had paralysis of left side of the face before she married, which always remained; also the right became paralysed after her labour, under a reducing diarrhœa; but this was recovered from. In the course of this year (1846), her paralysis of left side increased; she emaciated greatly; during these unfavourable changes, there was sickness and indications of pregnancy. In June she had become so feeble as to take to her bedroom, and after some weeks could scarcely get out of her bed to have it adjusted. She passed her water only once in 24 hours, and at length had great difficulty in speaking and in swallowing; all signs of her increasing paralysis, or increasing disease of brain. A tumor was felt in lower part of abdomen, but doubts were entertained as to its being a morbid growth or pregnancy. Dr. —— saw her with me, and we were both inclined to consider her emaciation and sinking the result of her disease of brain.—August 22nd, a surgeon from Bath chanced to be here, and on seeing her, concluded it was a tumor and not pregnancy; but not long after this, I felt the movement of a fœtus, and convinced myself of pregnancy, which I had never allowed the patient to doubt. She sunk in powers and in bulk as the pregnancy advanced—at the end of September, could swallow only liquids, and was much troubled with the mucus which she could neither swallow nor expel by the mouth—very threatening paroxysms of suffocation were produced by this. In the beginning of October, she was evidently sinking fast, relieving us from the fear of delivery at full term, which she could not have survived. On Sunday, October 11th, it was evident that death was approaching, and that she would not have to engage with delivery, unless premature. Having often felt a living fœtus through the very thin parietes of the abdomen and uterus, I pointed out to the husband and friends, that on her dying, particularly if suddenly, the moment might be embraced for removing the fœtus by a Cæsarean section, and thus obtaining a live child. I looked for her death in the course of the Sunday night, and took up my residence in her room at eleven o'clock, authorized to operate if I saw fit. After twelve o'clock,

I felt the fœtus move freely. I felt such free movement in more than one part of the uterus, that it struck me there might be twins; for the uterus had increased in size rapidly, although she was now only seven months gone or rather less. After one o'clock I did not feel the fœtus; but now and then, the uterus became tense, evidently from a degree of contraction, though not sufficient to open the os. It seemed at one time the patient would be soon suffocated by the mucus; and under such a sudden stop to life by the lungs and not by the heart, I should surely have obtained a living fœtus. But the urgency in that respect abated—the pulse sunk gradually, and she expired in this gradual way not until about seven in the morning—inspiration ceased—then was a long expiration, driving out nearly the last possible air from the lungs, a characteristic final expiration—at the next moment the pulse ceased at the wrist, and I instantly made an incision five inches long through the linea alba, and to some extent through the uterus; and in half a minute removed two dead male fœtuses. I suspect they had been dead some hours, as I had felt no movement. Had death taken place at twelve o'clock and less gradually, I should certainly have succeeded in preserving life; but the vital powers were gradually depressed low enough to be insufficient to supply the fœtal circulation, and hence the failure. The favourable cases for this operation are where sudden death happens by injury to brain—or by stopping of respiration—less so when the heart first stops; and yet, in accidents, with sudden loss of life, the fœtus may be saved though it will be still-born and require to be resuscitated.

Hemiplegia.—Case 104.

Mrs. P——, æt. 42; mother of several children. Six years ago had a slight paralytic stroke when pregnant, but went on to the full term of utero-gestation and recovered. Complained of numbness of right leg and arm some days before, and became quite hemiplegic of that side at midnight, September 2nd, 1827. Bleeding, blistering, and opening medicine employed. The liq. amnii began to dribble a few hours afterwards, and she was observed to strain as if in labour now and then, though she said she had no pain. In 24 hours, a child, between six and seven months, was born dead, and the placenta followed. Although she

strained, she did not appear to have the usual severe pain from the action of the uterus, and only called out at the last few pains, when the child was passing through the os externum.

Sept. 5th. She remains hemiplegic, but in all other respects seems doing well.

Case 105.

Mrs. B——, æt. 27; was seized with hemiplegia a month before delivery—she recovered considerably before labour came on, which was quickly terminated, the child being born before I arrived; it was dead, but had been living, I believe, until the time of labour, and certainly was felt to move just before labour commenced. Mrs. B—— expected labour daily when the paralytic attack came on—did this delay the accession of labour? I cannot solve the question. Labour took place on the 17th May. On the 9th of October, she had slowly recovered almost the entire use of the limbs, but is thin, and feeble in mind as well as body.

This lady recovered her strength considerably, and in 1845 was confined again a little before her expected time; her labour was rapid, and no paralytic symptoms occurred either during pregnancy or after labour.

Fracture.—Case 106.

Dec. 27th, 1829. I met Mr. E—— on the case of a woman aged 20, who, in advanced period of first pregnancy, 12 days ago, fractured the left tibia and fibula, by being thrown out of a gig—the tibia protruded by a large opening—five days ago, she groaned—a quick labour and living child—much hæmorrhage, so as greatly to reduce her. To-day I find a thrilling feeble pulse—flat and promising state of abdomen. The wound of the leg well open and good pus discharged. I urged food—beer—and wine if required, as exhaustion seemed the danger—no threatening symptomatic fever present.

Delirium.—Case 107.

Mrs. P——, æt. 35; first child; labour pains for 40 hours. Mr. R—— was with the patient eight hours before I came—os uteri had been for some hours fully dilated, and waters away. Patient manageable till last two hours, when delirium came on,

and she would not submit to be touched. Mr. R—— feared convulsions and called me. The room was hot, windows closed, (20th July), and patient in high fever and perspiration. I cooled the room, fanned the patient well, and in 1½ hour this state of alarm subsided, and she submitted to be examined—child's head low, and perineum relaxed; but as it was thought the head had advanced a little in the last two hours, I advised waiting three hours more. Pains went on regularly; but as the head, at the end of that time, had not advanced, I applied the forceps very readily, and a living male child was born in a few pains. The patient had no recollection of what had passed during the state of hurry and delirium, which condition had been brought on as much by heat of the room as by long continuance of the pains.

Mania.—Case 108.

Mrs. W——, a particularly nervous and excitable subject; her whole night's rest would be disturbed by the unexpected observance of an insect near her; her health delicate. She expected her confinement in the middle of May; first pregnancy; and in the beginning of March I commenced attending on account of cough and cold. She had pain in the right side of the chest, to which a blister was applied; every evening, for a week or two, she had a little fever; her cough abated, and health improved; but I still kept her to her room, as the slightest fatigue made her relapse. In the beginning of April, she for several nights awoke hurried, desponding, and distressed, out of her first sleep; and she was troubled with a pain on the right side of the spine, just below the scapula, to ease which she requested her husband at night to press with his hand, or support by a pillow. At midnight, April 13th, I was suddenly summoned; she had been sleeping half an hour, and awoke distressed and perturbed, seeking for something on the bed. I found her expressing herself most despondingly that she was dying; she talked incessantly in the most desponding terms, using expressions harassing to the feelings of those around; and not only took affectionate leave of her relatives present, but would not be pacified without taking leave of the servants.* Pulse 160, and every pulsation of the

* There were some circumstances which might tend to make Mrs. W——

heart could be heard—her principal complaint was of coldness in the chest, extending to the arm-pits; but the limbs were warm. Though talking of dying every moment, she walked from her bed to the fire-side in the adjoining room. I was with her four hours —the despondency somewhat abated; some warm drink was taken—she at first thought she might live half an hour; then several hours; and at length allowed she might possibly live till the morning. She got no more sleep, and next morning, when I saw her with Dr. W——, she was laughing and hysterical—she was amused with her own whimsicality in the night, particularly that when she wanted her pocket handkerchief, she could not call it by name, and could only describe it as something square. She vomited a green bilious fluid, after which headach and pain in the back were much relieved—at every visit this day, I found her laughing uncontrollably, which went on till it ended in crying; and every new face brought her to the same state—her pulse however got quieter as the day went on, and in the evening was only 90. She took only liquid nourishment, and fair evacuations were obtained from the bowels. The next night she was restless, and began to give marked signs of raving and insanity—talked incessantly and incoherently, and had such muscular power, that three or four assistants were required to keep her on the bed, and prevent her doing injury to herself and others. She began to talk about her labour, and expected a miracle to be wrought in her favour, and the child to be born without pain. The alternate states of gaiety and lowness, dislike to those she most valued in her well moments, noisy eloquent vociferations, and all the usual characters of a maniac continued. She got scarcely any sleep—had no pain—coughed very little, and that chiefly when she was least violent—her pulse would be as low as 90 when she was quiet, but rapid when by great exertions she brought on heat of skin and perspiration—she was allowed plenty of broth, but no stimuli, and very little solid nourishment. The night of the 23rd, Saturday, was passed in incessant talk-

apprehend, in an unusual degree, the consequences of her labour. Her mother died of convulsions; she was present at the first labour of her sister, Mrs. B——, who was just lost in syncope, but brought back by an hour's perseverance in giving brandy; the first wife of her sister's husband also died in childbed; and the first wife of her own husband died a few days after labour, only two years ago.

ing and raving, without sleep; and early on the Sunday morning, I observed her to strain as if she had labour pain—in the forenoon she gave distinct expression of labour pains coming at regular intervals; and on examining, I found the os uteri dilated, and the child's head descended. She would not, however, be persuaded that it was labour; but whenever a pain came, she attributed it to a slow burning poison she had taken, and called aloud for a quicker death, by drowning, shooting, or lightning. The pains went on regularly for four hours (she was utterly unconscious of, and inattentive to, my examinations *per vaginam)*, when a dead fœtus was born. It must have been nearly nine months, and had been some days dead, the cuticle about the scrotum detaching, from commencing putrefaction. The placenta soon followed, with rather less coloured loss than usual on such occasions. The patient after this was more quiet for a few hours, but not rational; had no knowledge of what had happened—and when told of a still-born child having been produced, expressed her suspicions that all had not been right. The tongue was dry after many hours' raving, but got moist and clean when she was quiet for an hour. Sufficient lochial discharge daily—she did not refuse the mild nourishment offered, but her strength began to fail—the pulse was constantly weak and rapid—she talked with equal violence and incoherence, though unable to talk loudly. A blister had been applied to the nucha, and the hair cut off.—The Tuesday morning after her labour she was so low that Dr. W—— recommended wine and water; and good broth was plentifully given—tongue furred and dry in the evening—countenance vacant and fatuitous—pulse small and 150—subsultus—breathing slow and not short. At mid-day, on Wednesday, April 27th, she expired. For 24 hours previously the urine had passed involuntarily, was dirty like muddy ditch water, and the discharge from the uterus was offensive. I inspected the body 48 hours *post mortem*. There was no trace of inflammation, nor its consequences, in the membranes of the brain—the medulary substance of the cerebrum shewed numerous red points of vascularity, and the veins of the pia mater were very turgid—about two or three drs. of fluid in the ventricles. I examined the spinal marrow very extensively—found no effusion or trace of inflammation, but the veins much distended. It did not appear that

there had ever been inflammation of the pleura; and chief part of the lungs were in a healthy state; but at the posterior part of the right lung near its root, there was an abscess, containing a spoonful or two of pus, with surrounding hardness. Some tubercles, and a considerable mass of calcareous deposit. In the abdomen there was no morbid appearance—no coagulum in the uterus, but some half-putrid grumous blood.

The mental malady had in this case produced no corresponding morbid appearance; and one could only say, that the brain and spinal marrow were full of blood, whilst the rest of the body was pale—the substance of the heart was particularly pale and bloodless. The pain so much complained of on the right side of the spine answered to the situation of the abscess at the root of the lung.

Case 109.

A woman, aged 40; in her 14th pregnancy. When six or seven months gone, she had slight hemiplegia, which bleeding relieved; but she had giddiness and headach, and when above eight months gone, became insane. In six or seven days she died, but 24 hours before death, the fœtus was expelled without her seeming conscious of it, she being raving and violent at the time. She was an intemperate woman, but the prevailing idea was that her husband had given her venereal disease. Mr. T—— attended, and employed active bleeding, &c. Uterus well contracted, and containing only a little coagula; abdominal and thoracic viscera all healthy; a patch or two of lymph under the arachnoid at the top of the cerebrum, but very slight; the brain so vascular with red points, that we called it inflamed—several ounces of fluid in the ventricles; the cerebellum was soft; the rest of the brain very firm; membranes of ventricles pale.

Case 110.

Mrs. A——, mother of 11 children; with her last in April, a quick time; the surgeon on arriving, finding the patient on the floor at one corner of the room, and the child and placenta at the other. I was called into consultation about this lady above a month after labour, nervous symptoms having come on; great sensibility to light and sound; a whisper felt as loud speaking;

small quick pulse; pain in the head; so much emaciation and debility that it seemed difficult to determine on the propriety of reducing measures—leeches were applied to the temples, but faintness was induced and no relief; mild tonics; opiates; head shaved, and evaporating lotion. I thought there was subacute inflammation of the membranes of the brain; but really felt not quite sure whether it was not direct debility and nervous disorder, without inflammatory disease. A week after our consultation, Mr. C—— reported the patient to be much the same, he feeling he could only adopt mild tonic and soothing treatment. Next day she became suddenly excited; then quite maniacal, with a quick weak pulse; and in this state she continued for three or four days, when she became suddenly calm, but not sensible; and in a quarter of an hour expired.

On dissection, Mr. C—— found "the dura mater nearly free from disease, except that there were a few *adhesions* between it and the tunica arachnoides; the longitudinal sinus was empty; The tunica arachnoides was extremely inflamed, and about 3 oz. of fluid were effused between that membrane and the pia mater. The cerebrum itself was much injected, exhibiting, when sliced, very numerous bloody points. The lateral ventricles contained but a very small quantity of fluid. The cerebellum was also much injected, and its arachnoid membrane covered with an adventitious membrane of fibrine. These very decided proofs of inflammation make me deeply regret that I had not insisted upon more free depletion in the first instance; but the effect produced by the first leeching made such an impression on Mr. A.'s mind, that he positively forbad a general bleeding which I had proposed the day before your visit, and which he has since told me no advice would have induced him to consent to. This case occasioned me great anxiety during its course, and has given me much pain by its result."—My reply to Mr. C—— was, "To men whose minds are intent on the strict performance of their duty, there is always a satisfaction in being enabled to come at the truth, after doubt and uncertainty. Your account of the post mortem inspection of our patient does settle the question of inflammation of the brain having existed, producing the morbid appearances you noticed; but I cannot go the whole length of your inferences as to the good effects antiphlogistic treatment might have produced; *first*,

because it is not universally believed, nor by any means rendered indubitable, that every case of local inflammation is benefitted by free general bleeding; indeed, so far from it, that I think I have known feeble and emaciated persons sinking quickly under such treatment (particularly when the brain or its membranes were the parts suffering), who might have contended long, or have eventually recovered under different management. Some most experienced men have forcibly dwelt on the danger of freely bleeding certain maniacal patients.—*Secondly*, in the case of Mrs. A—— I do verily believe that the disease in the brain came on insidiously, and had in all probability made such progress before you were called in, as precluded effectual relief from bleeding, locally or generally, and perhaps rendered it altogether improper."

Case 111.

In April, 1842, Mr. B—— called me to a young woman, aged 20, in violent raving mania 14 days after delivery with her first child. She was rather a delicate and a very nervous and excitable subject. Leeches had been largely applied to the temples; I cautioned against further depletion; the child living; mother's milk left her on the accession of mania. I thought the case uncertain in its issue, although puerperal mania is usually recovered from. This patient was soon after taken to Norwich Bethel, where she was on the 31st of May.

July 23rd. Still insane in Bethel.

Case 112.

Mrs. S——; second confinement was succeeded by acute puerperal mania; was so very bad, that restraint became necessary; I saw her twice; after a few weeks, she got well enough to go to the sea-side, and eventually recovered perfectly.

Cramp.—Case 113.

Mrs. L——, æt. 42; 10th pregnancy. This labour terminated by natural efforts, and with a normal presentation; but was tedious, and attended with the most distressing cramp of the right leg for the last hour or two, whilst the head was in the pelvis. A living girl, of ample size, the result.

The first two labours of this patient were got through with

living children, though with much delay; one a girl, the other a boy of small size. Since then, she has had six labours at full term, exclusive of the present; three, with girls, have been natural and pretty quick, owing most certainly to the female head being smaller; three boys difficult, requiring with two of them embryulcio, and with the third, long forceps. In the labour of the present year she recovered well, having no unfavourable symptom after delivery.

Remarks.

When a woman, at the time of labour, is in a good state of health, free from organic disease and congenital deformity, she generally passes through child-birth, exempt from danger or disease. But the state of system induced by parturition, nevertheless, has a tendency to render her more *susceptible* of impressions of various kinds; and should any disease appear at the time, it will probably be modified by this condition of the organism. The first two cases in this chapter are instances of disease being aggravated by the concurrence of labour; most of the others exemplify the fact that parturition renders the system liable to the supervention of other maladies.

No affection accompanying labour is perhaps more distressing to witness than convulsions; when severe, they have the appearance of being necessarily fatal, and the bystanders look upon death as the inevitable and not distant result. Yet experience teaches us that convulsions may frequently be cured by proper treatment; and that so far from the patient having undergone great suffering during the frightful paroxysms, she recovers without remembering anything about what had occasioned so much consternation and dread amongst her friends. It would seem as if the convulsions were the effect of a temporary paralysis, so to speak, of the brain, deadening sensibility,

and allowing the spinal nervous system to run riot, in perfect freedom from the controlling influence of the cerebrum. In the preceding twelve cases of puerperal convulsions, only one mother died, although loss of life to the children was in larger proportion. The practice has, therefore, been eminently successful, and the appropriate, because successful, treatment has been sufficiently pointed out in the cases themselves; it must, however, be constantly borne in mind, that convulsions may arise from very different and opposite causes, requiring great attention on the part of the Accoucheur to discover the proper indications of treatment; so that were he to resort, without due consideration, to any one unvarying plan of treatment in every case, his practice would fail of the success which attends the efforts of the intelligent and discriminating practitioner. In four cases, which occurred in my practice in the country, all the mothers and three of the children lived. In one attended by another surgeon, to which I was called after many hours, both mother and child died; and although bleeding had been very fully practised, the appearances after death were those of enormous sanguineous congestion of the brain and spinal marrow. In one of my own cases, the child's head was opened on account of narrow pelvis and insuperable impaction; and as it well exemplifies the possibility of perfect recovery after very severe and repeated attacks of convulsion, I here insert it:—

On the 31st of October, 1843, my assistant was summoned to attend M—— A——, in labour with her first child. She was a single girl, about 18 years of age, strong, muscular, and in good health. After he had been with her eight hours, he sent for me to assist him. I found a swollen scalp, an impacted head, regular and very strong pains, membranes ruptured, vagina hot, and no advance during pains. I tried both vectis and forceps patiently, but without success. After I had been there some

hours, the labour having made no progress in spite of regular and severe pains, she became suddenly convulsed in a frightful manner; countenance turgid, respiration loud and embarrassed, pulse full and rapid. I immediately bled her freely, and in about five minutes she became conscious. Having previously failed in my attempts to deliver with instruments, and the case becoming urgent, I determined to open the head; portions of brain were then squeezed out during each pain, but before I could deliver even the head, another convulsion came on. I again bled her with the same good effect as before; and then, with vectis applied over the chin, completed the delivery, although there was considerable resistance to the passage even of the reduced head, and the shoulders. She had then a third convulsion, and was bled a third time. I then removed the placenta, and the uterus contracted very firmly. She had again become sensible; and I hoped, as the uterus had been emptied, she might go on well. However, in about half an hour, another severe convulsion took place; countenance bloated and distorted, limbs much agitated, pulse very rapid, frothing at the mouth, &c. I began to despair, but resolved to bleed again; and after a while, she a fourth time returned to a state of consciousness. She complained of considerable headach, and her pulse was firm and rapid. In about three hours, she experienced a fifth convulsion, as severe as any of the others, and was a fifth time bled with the same success as before. She was strictly watched for several hours, but nothing further occurred. Her headach was severe the next day, and was relieved by leeches; she had a good deal of muscular pain and soreness, difficult to distinguish from abdominal inflammation, relieved by poultices and opiates; she was feverish for several days, but able to sit up at the end of a fortnight, and soon after got perfectly well.

Puerperal mania is fortunately not a common occurrence, but one which, when it does happen, usually creates alarm both to the friends and to the medical attendant; to the former, from a fear that death or permanent derangement may be the result; and to the latter, from a conviction that his individual experience has

not been sufficient to enable him to prognosticate with anything like certainty, the progress or ultimate result of the complaint, nor to supply him with well-determined views of treatment. This latter remark is not applicable, probably, to the few who have the most extensive opportunities of becoming familiar with every occurrence connected with the practice of midwifery; but of the vast majority of practitioners, both in provincial towns and in the country, it may be said with truth, that cases of puerperal mania are treated by them with a measure of that indecision and uncertainty which nothing but experience of the disease can dissipate. There is a remark appended to one of the preceding cases to the effect that "puerperal mania is usually recovered from;" whence it may be presumed that the cases here reported represent the disease in its most severe and intractable form, since, in five cases, three of the mothers died, and one remained permanently insane.

As far as I am able to judge from what I have seen as well as read, the writings of the late Dr. Gooch furnish the most useful information on this important subject; and I trust the following brief abstract of the opinions and practice of that intelligent accoucheur, will be acceptable to those who may be inclined to peruse the preceding cases. Dr. Gooch observes,

"There are two periods at which these disorders (of the mind) are mostly liable to occur, the one soon after delivery, when the body is sustaining the effects of labour; the other several months after, when the body is sustaining the effects of nursing." "There appear to be two forms of puerperal mania, the one attended by fever, or at least the most important part of it, a rapid pulse; the other accompanied by a very moderate disturbance of the circulation; the latter cases, which are by far the most numerous, recover; the former generally die. Some cases which were attended with a quick pulse recovered; but

none of these were treated for paraphrenitis." "Mania is a less durable disease than melancholia; it is more dangerous to life, but less dangerous to reason. Of the many patients about whom I have been consulted, I know only two who are still, after many years, disordered in mind, and of these one had already been so before her marriage."

It is also remarked by Dr. Gooch, that the chances are much against a patient who has been disordered in mind after one lying-in, being so after another, the proportion of cases in which the disease occurs twice being very small. With regard to treatment, he observes,

1. The constant attendants on the patients ought to be those who will control her effectually but mildly, who will not irritate her, and will protect her from injury. These tasks are seldom well performed by her own servants and relatives.

2. The diet ought never to be very low; and if the disease after many days continues unabated, a daily portion of solid meat may be necessary, and the rule for it is this; if there is nothing in the bodily symptoms, separate from the disorder of the mind, which forbids it, this state of mind is no objection to, but rather an argument for, it.

3. The result of my experience is, that in puerperal mania and melancholia, and also in those cases which more resemble delirium tremens, blood-letting is not only seldom or never necessary, but generally, almost always, pernicious.—*Rule.* Never use bleeding as a remedy for disorder in the mind, unless that disorder is accompanied by symptoms of congestion or inflammation of the brain, such as would lead to its employment though the mind was not disordered; and even here great caution is necessary; local is safer than general bleeding. Pain of the head, with fever, is a much better indication for blood-letting than disorder of the mind without these symptoms. If the powers of the constitution are not low, and the gastric symptoms are very marked, an emetic, not of antimony, but ipecacuanha, may be given. When the stools are very unhealthy in colour and odour, one or two active purges ought to be given: where, however, the gastric symptoms are very slight, and the powers of the system

much exhausted, active and prolonged purging is injurious. The most valuable medicines in the treatment of puerperal mania are narcotics. These remedies produce salutary effects much oftener in the mania of lying-in women than in mania occurring under other circumstances; for it is more uniformly a disease of nervous excitement and debility. If the head is hot, the cheek flushed, and the patient thirsty, they ought to be postponed; but if these symptoms have been removed, or are not present, sedatives ought to be given, and the most efficient, first. When once opiates have attained their object, they should be withdrawn, not suddenly, but gradually; diminishing the dose, lengthening the interval, watching the effect of this abstraction of the remedy, mending the diet whilst withdrawing it, and returning to the old doses if the diminution of them occasions any unfavourable symptom.

4. There can be no doubt that it is generally necessary and useful to separate the patient from all those persons who are sources of excitement of any kind.

Account of some of the most important Diseases peculiar to Women, by R. Gooch, M. D. Chap. 2.

I may here make allusion to another affection, which, although generally manageable enough when uncomplicated, is occasionally of serious import when connected with the puerperal state, and may be instanced as a good example of what I have previously mentioned, the increased susceptibility of the system at the time of parturition. The disease I refer to is Diarrhœa, or "intestinal irritation," which may come on either before, during, or after child-birth; and in either case, may lead to serious if not fatal symptoms. A mode of practice which is common, and forms part of a general routine, is perhaps for the most part safe; but it may occasionally be hurtful if employed without discrimination, and its being common may put us off our guard. Nothing is more usual than to give a purgative a day or two after delivery, and generally no mischief follows; but the fact, that aperients may produce, under certain circumstances, severe and dan-

gerous symptoms, should warn the Accoucheur not to administer them either too freely or too early after labour; indeed, to be very cautious in employing them at all unless a necessity for them is apparent. Lieutaud represents medicines of this description as very dangerous after labour, and says that glysters are the only admissible means of procuring alvine evacuations at an early period after delivery.—The following case, from my own note book, is an instance of the occasional danger and difficulty arising from the exhibition of a purgative:—

E—— W——, æt. 39, in labour with her fourth child; attended by a midwife, who went to her on the evening of Sunday, April 5th, 1845. She remained with her all that night and next day, when in the evening (6th) she sent for me, owing to the slowness of the labour and the anxiety of the friends. The patient had for some weeks been suffering from piles and prolapsus ani, which she attributed to a strain. I found labour in an early stage, although she had had pains for many hours.—When the uterus appeared sufficiently dilated, I ruptured the membranes, and let off *an excessive* quantity of liq. amnii (not unfrequently a hindrance to the progress of labour). The pains then became more effective, and the labour soon terminated without further trouble, except that the birth of the head was a little delayed by the cord being twice round the neck. Placenta soon followed; no hæmorrhage; all promising well. Returned the prolapsus ani after delivery, and gave an opiate. On the 8th, Mr. —— called to see her for me, and found all right except a little griping occasionally, for which he ordered ol. ricini ℥j. tr. opii m.x. This soon acted on the bowels, and then she had pain in the body at intervals, with severe purging all night.

9th.—On visiting her this morning, I ordered 10 grs. of Dover's powder every four hours—the pain and diarrhœa continued—prolapsus large and painful—abdomen rather tender; could not bear the prolapsus ani returned, so I left it down, and advised fomentations and poultices to be applied to it. Gave a draught containing sp. æth. nit. and tr. opii every four hours, and 15 grains of compound kino powder after each stool.

10th.—Pain less, but diarrhœa still continuing—stools mucous, bloody, and watery. Mist. cretæ. opii catechu post sing. sed. liquid. In the evening, the motions were of better quality, and not so frequent ; prolapsus less painful ; but she was much exhausted, with a pulse nearly 150.

11th.—Less diarrhœa and very little pain—abdomen soft and not tender ; pulse rapid ; profuse perspiration and extremely faint. Haust. ammon. lavend. catechu, when faint.

12th.—Bowels still acting every two or three hours, but motions fæcal, without blood. Was better this morning until she had eaten a small piece of boiled beef, which some neighbour had been injudicious enough to send her ; when she had a violent "spasm," with difficult breathing, and was in great jeopardy.—Ordered sago and port wine. A pill with gr. ij. plumb. acet. and g. j. pulv. opii, every four hours ; and, this failing, dec. hæmatox. with dram doses of tr. catechu. Abdomen soft ; pulse rapid and small ; perspiration great ; much depression. Gave strict injunctions for her not to be raised up in the bed, for fear of syncope.

13th.—Free from pain, and in all respects better this morning. Pulse 120 ; perspiration less ; but the bowels had acted five times since my visit yesterday. During the night, she had taken no medicine but the opium and lead pills, which did not stop the diarrhœa ; the logwood mixture was now given instead ; and in the evening I heard there had been only two motions, and those small ones, during the day. Takes sago and port wine freely.

14th.—Passed a comfortable night, without pain or diarrhœa. Takes a spoonful of the logwood mixture every two hours—complains of soreness of the mouth and throat. In the evening, she felt sick, and had a slight return of diarrhœa. Mouth aphthous ; debility great. To take the mixture after each motion, and a pill containing pulv. kino c. and extr. hyos. every four hours.

15th.—Could not take the pills, but continues the logwood and catechu mixture, which keeps the bowels most under command. Pulse down to 100. Mouth sore, with bronchial irritation also. To take pil. sapon. c. opio g. v. occasionally for the cough.

21st.—Since last report, she has continued the opium pill for the bronchial irritation, and mist. hæmatox. c. for the diarrhœa,

which has abated so that she has a motion not oftener than three times in the day and night. Voice almost inaudible ; pulse 120 and weak—but says she feels much better. Continues the medicine, and takes freely of port wine, sago, gruel, &c.—After this time she gradually improved, the diarrhœa ceased, and she slowly but completely recovered.

There are several points in the case just reported which are not unworthy of consideration. In the first place, it shews that purgatives cannot always be given with impunity soon after labour, especially when, in addition to the usual increased susceptibility of the system, there exists a tendency to irritation of the bowels from piles, prolapsus ani, &c.

2ndly. It exhibits the ill effects of an error in diet during the existence of intestinal irritation, which in this instance nearly proved fatal.

3rdly. It proves that in some cases it is better not to return a prolapsus ani; for by that means it may become extremely painful from the constriction of the sphincter, and possibly communicate irritation or inflammation to a neighbouring organ, in a susceptible state, the uterus. Here the prolapsus could not be kept up without exciting considerable uneasiness, and retired of its own accord after repeated fomentations and poultices.

4thly. The aphthous state of the mucous membranes, and the rapidity of the pulse, indicated a degree of debility from which recovery can seldom be expected.

5thly. The case also exemplifies the utility of changing the medicine as soon as it appears useless or prejudicial, for another of similar properties; here astringents were strongly indicated, but several of them failed, logwood and catechu answering far better than the rest. The beneficial effects of opium, also, in allaying irritation of

the mucous membranes, and keeping up the capillary circulation, were very apparent.

But in thus guarding against danger from the incautious administration of purgatives, we must be equally careful to avoid the other extreme; for if the bowels are allowed to become loaded, especially the rectum, after-pains may be kept up, irritation of the bladder excited, even hæmorrhage produced, by the irritation thus occasioned. There can seldom be the slightest objection to a glyster of warm gruel on the second or third day, and this will generally suffice for removing the contents of the lower bowels, and obviating the occurrences just referred to as consequences of constipation; if, however, there exist signs of disordered stomach, furred tongue, dislike to food, headach, &c., these constitute sufficient indicacations for the administration of aperient medicine, castor oil, or senna; but the dose should never exceed what may be required to unload the bowels without producing purging.

CHAPTER X.

DISEASES OCCURRING IN CONSEQUENCE OF LABOUR.

Flooding.—Case 114.

Mrs. E—— has had several children; a pale exhausted woman; her present labour was quick and natural; placenta in a short time came away perfect—before her surgeon left the house, she fainted and much blood was found in the bed. I was there in half an hour, when a pint of port wine had been given—cold vinegar and water applied to the abdomen; the room cooled, &c. There was a slight oozing of blood—patient looking almost lifeless, gasping for breath—pulse not perceptible at the wrist and scarcely at the heart. As the wine was likely to regurgitate, I gave brandy, which was continually supplied. The flooding having ceased, I considered it a case requiring stimuli; got the room warmer—for some hours the pulse was scarcely perceptible; and it was nine or ten hours before she revived so as to be in a flattering state towards recovery—she did, however, revive perfectly.

Case 115.

Mrs. A——, mother of a large family; easy labour; placenta came away properly. After an hour's absence, her surgeon was summoned on account of hæmorrhage and fainting. By proper measures, these were removed; but Mr. R—— was again called on account of fainting coming on by the patient's raising herself up; this continued for six or eight hours, with coldness, imperceptible pulse, gasping for breath, death-like paleness. At the

end of this time I was called—hæmorrhage had ceased, and the faintness and exhaustion were the threatening symptoms. Warmth, wine, brandy, and æther, were used, with recumbent posture; but the patient sunk in four hours. She was feeble and reduced before the labour came on.

Case 116.

Mrs. D——, æt. 35; first pregnancy; labour regular; and an hour and half after the placenta had been expelled, there was great faintness—some outward loss—uterus very distended.—Mr. S—— gave stimulus; emptied the uterus of coagula; gave ergot. I was called; a slight loss continued for some hours; and nearly 12 hours elapsed before the patient recovered so as to be in a satisfactory state. Ice was applied to the lower part of the body with very good effect. She did well afterwards.

Case 117.

A woman, æt. 29: fourth pregnancy; twins born; flooding supervened. I was called when she was almost lifeless; I closed the windows, removed wet vinegar cloths, and gave brandy and water; for the flooding had long ceased, and she had scarcely a pulse. She died in an hour or two.

Case 118.

Mrs. D——, second pregnancy. An hour after regular delivery, had a great loss inducing syncope, the same as in her first labour. Her surgeon introduced his hand into the uterus. Brandy given freely; at times the pulse could not be felt. I was called—she had rallied before I arrived, and she revived five hours after labour. She recovered.

Case 119.

Mrs. S——, second pregnancy; labour regular—but I was called four days after; found her pallid as a sheet, and with small pulse, from loss since her labour; this was still going on, several large coagula having passed within the last few hours. She was so much reduced, that her case was threatening. Clean linen, nourishment, warmth (for I regarded the loss of a passive kind), with wine when faint, restored her.

CASE 120.

Mrs. G——, æt. 42; eighth pregnancy; expected she was only eight months gone—called me at 2 p. m. April 21st, when I found her countenance pallid, lips quite blanched, pulse small and rapid, skin cold. For three or four days she had suffered much pain, constant, in the pit of the stomach—sickness to-day; costive bowels; occasional increase of pain with straining; yet did not think herself in labour. I gave some aperient doses in pills and a mild aperient mixture. At 9 p. m. I went down—found so much pain at fundus uteri, with tenderness on pressure, that I thought there had been inflammation of the uterus going on and now severely present—regular uterine pains came and went—same pale, cold, almost lifeless state. I found the os uteri open, and head of the child near os externum. I feared syncope after labour, and gave beforehand some gruel and a tea spoonful of brandy. A dead child was born at 10, and when I had removed it, I found the placenta in the bed, expelled completely by the uterus. I gave again gruel and brandy—a considerable loss went on; faintness, jactitation, cold surface; large coagula expelled; body supported with bandage; all usual precautions, except cold and vinegar, which I thought unsuited to a case where great debility and bloodless state before delivery were the cause of the present alarming syncope, rather than profuse hæmorrhage; still there was considerable loss. I gave brandy freely, with warm gruel. Called Mr. D——, who sanctioned the same line of treatment, with warmth, warm room, hot water bottles to feet and legs. For two or three hours, whilst we were both present, the pulse could sometimes not be felt; at others, it was easily perceptible, but so quick as scarcely to be reckoned—we feared the worst, as distressing jactitation, heaving in breathing, and exclamation for air, returned at intervals. In six hours after labour, the skin had become warm—the stomach throughout had retained the nourishment given—pulse steadily perceptible—more quietude and regular breathing—gruel still given with milk and a diminished quantity of brandy. In nine hours I ventured to adjust the bed linen, move the patient a little, and leave her for a time.

Although I apprehended syncope, the distressing and alarming symptoms did not come on till above an hour after delivery;

and had I trusted to the patient's account of herself, who was cheerful, thinking only of the relief she had gained from pain, I might have quitted the house—all pain had left her, discouraging my fears that inflammation of the uterus had been going on some days; and she expressed herself well; but I looked to her pallid countenance, cold skin, colourless lips—small rapid pulse—to the increasing size of the uterus, as blood came more and more into it—at length I found considerable flooding—then suddenly came on the great distress as described. The accoucheur, therefore, should attend not so much to the patient's account of herself as to the state of the patient, and by this be guided as to leaving her; feeling the body as well as the pulse; and if there be any suspicion of loss, examining not merely the napkins removed, but by ocular inspection of the parts, contrary to the general rule. For want of this, I have known the practitioner recalled to a dying patient, whom he thought he left well, because she reported herself so. The precautions I here inculcate will enable one to judge when to remain an hour or two after delivery, which in ordinary practice cannot be done with every patient, and is not often needed.

In the course of the next day the patient was flushed—pulse forcible. On the second day, she became very feeble—pulse 160—pain in lower part of the abdomen, and next morning a blush on the right hip, as if from lying on it—this spread, and vesicated in the centre—the florid surface was raised, shewing thickening of cutis—it spread gradually, so as to occupy all the right buttock, reaching towards the loins, and inside of the right thigh. I refrained from lotion, using only hair powder, lest repelling it (which perhaps came from within, existing, probably, in the abdomen before labour), the head or other internal part should become affected. This patient was little delirious, but hurried, verging on insanity. Ten days after labour, the erysipelas had ceased to spread, and was faded, nearly gone—strength improved—pulse from 100 to 120—mind not correct. In a few days the mind quite recovered, a blush on the dorsal side of the left fore-arm appeared, with swelling and ædema—this ended in suppuration; and on the 13th of May I opened it, evacuating a large quantity of pus.

May 17.—Now I think there is threatening of suppuration on

the right hip, where the erysipelatous inflammation was situated; small glands are enlarged in the neighbourhood, one on the outer side of the thigh—health good.

July 1.—Several small abscesses formed on the right hip, which are even now not healed, though the patient is so far recovered as to get abroad. Let it be remembered that two or three weeks after labour, there was a sudden gush of matter from the vagina, proving an abscess to have burst, and supporting my idea of internal erysipelas.

The nurse attending Mrs. G—— was taken ill and died of erysipelas.

Case 121.

Mrs. ——, æt. 25; first child; 24 hours in labour; child delivered by natural efforts; hæmorrhage followed; hand introduced into uterus to remove placenta; found uterus full of blood and flaccid; loss went on till there was great faintness. Cold wet cloths applied to abdomen; and just before I arrived, 1½ hour from delivery of the child, a little brandy had been given; still great pallor and a small pulse; feeling of sickness. The uterus was contracted and small before I arrived, and no external loss was going on; so I placed dry napkins, and made the patient lie more comfortably; ceased moist applications, and gave a little brandy and gruel in small quantities. Pulse became rather better, and lips not so pallid; still when I left, the patient was tossing and wishing to turn to a fresh side. In the course of the day, I heard she was doing well; and she recovered favourably.

Case 122.

Mrs. ——, æt. 42, mother of several children. Mr. B—— called me, on account of flooding after the child was born. When I arrived he had just removed the placenta, and the patient was rallied. I introduced my hand into the uterus, found no part of the placenta remaining; recommended a little more stimulus, some having already been given. The serious loss was over before I arrived.

Case 123.

Mrs. W——, æt. 37; fourth pregnancy. A very large child

was born, with a few pains, before I got there. The placenta was low, partly in the vagina; but there was much loss before I arrived, and during the few minutes before the placenta was removed—the loss indeed was so great that the pulse could not be felt; distressing syncope became developed; and although there was scarcely any loss after the first quarter of an hour had elapsed from completion of delivery, and the uterus could be felt small, proving there was no internal hæmorrhage, I felt obliged to remain five hours, giving, at short intervals, a few spoonfuls of gruel with as much brandy, for the pulse could often be scarcely felt—jactitation came on, and I was in much doubt about the result. In a subject of good strength and ample supply of blood, and where the loss is still going on, cold, such means as induce contraction of the uterus, ergot, are proper; but here there was no loss going on; no additional contraction of the uterus wanted; and the syncope was from inability of the patient to rally after the loss already sustained. I had difficulty in getting the surface of the body generally and the extremities warm, laying at length much flannel over the patient. The refrigerating plan would not have answered otherwise, I believe, than to destroy, and is inapplicable to a great majority of cases of metrorrhagia. Altogether I gave 6 or 7 oz. of brandy and a pint of gruel; and was in great alarm when my patient, though still distressed with a feeling of faintness, protested against taking more gruel, and complained of oppressed stomach. It was six hours before warmth of skin, and a regular pulse, such as I could trust to, were restored.

Case 124.

Mrs. G———, æt. 28; advanced to the seventh month of her third pregnancy, June 28th, 1839. Pains began in the morning, increased so as to be considerable by mid-day; child born at 5 p. m., and Mr. ——, who was pledged to attend, did not arrive till some time afterwards. Great flooding had already taken place, and he found it requisite to remove the placenta by hand, and says it was situated at the fundus of the uterus, with an hour-glass contraction, the inferior part continuous with the os uteri being quite relaxed. The uterus would not contract after the removal of the placenta—flooding continued profusely, till the

patient, a strong plethoric woman, was just pulseless—pallid—tossing. Wine and brandy were given; cold lotions applied to the uterine region; hand introduced into the uterus; still no uterine action. Two or three times the patient dosed, rallied a little so that the pulse could be felt—then on awaking there was fresh loss and syncope. This state continued for four or five hours, and I did not arrive till 10 p. m. I could then just feel the patient's pulse. The surgeon's hand was then in utero—on his removing it, I did not find any loss externally. The patient retained all she had taken. I placed dry linen next her, removing foul and wet cloths—also put a belt firmly round the waist—gave occasionally gruel, with brandy or port wine. No external loss occurred after I arrived—and at 1½ a. m. I left, the pulse having rallied sufficiently to make me satisfied there would be no relapse. In the course of next day, I heard the patient was doing well.

It is said that a week or two ago, by some sudden exertion, this lady committed injury, and had a loss of blood *per vaginam*. Supposing no partial separation of placenta to have been thus occasioned, and knowing there was no malposition of the placenta, I should explain the flooding to be from plethora, the consequence of free living. She is a full, fat person; and I know that such plethoric state disposes to flooding. I had here to treat the patient only after external flooding had ceased, and the course was obvious—to rally the patient and promote an uniform distribution of blood over the system. The infant died in a few days; the lady recovered.

Case 125.

Mr. —— attended a young woman, about 20 years of age, first pregnancy; and after an easy time, a healthy child was born—having put a belt on the body, he left, all being right, at one o'clock a. m. In an hour or two he was sent for on account of pains; but believing them to be after-pains, he did not go, but sent an anodyne. At 7 a. m. an urgent message, representing great pain and faintness, brought him to the patient; when, he says, he found the uterus distended with a large quantity of blood; to this he attributed both faintness and pain, for there had been no external loss since delivery beyond what is quite usual. Mr. —— thought it necessary to introduce his hand into the uterus

and remove the coagula, which were at least three pints. The patient became very faint. I was called most urgently, and was soon there—found the pulse perceptible ; soon there was colour in the cheek and she rallied—the uterus was empty and small, lying on the right side of the abdomen, where Mr. —— had held it fast. I soon left, entertaining no doubt the patient would soon rally.

I know not what to make of the case ; whether there was really any ground of alarm, or the surgeon frightened too soon—certainly the quantity of coagula in utero was very great. The time of my seeing the patient was 8½ a. m., being 7½ hours after Mr. —— left the patient well after a regular labour. There was no further trouble after I left.

Case 126.

I was summoned to Mrs. W—— about midnight, and an easy regular labour terminated at one o'clock on the Friday morning, without any untoward circumstance ; but as she had shewn an hæmorrhagic tendency,* and was in the most critical danger at her last accouchement, I waited with her two hours after delivery, and left her well in every respect. I called again the next day ; as to looks, pulse, manner, and in every observable respect, she was then doing well—gave me the best account of herself—had passed some coagula, but suffered no considerable loss so as to attract attention or depress her powers. But in the course of this evening, she experienced some sickness and faintness. I was not called until one in the morning (Sunday, 48 hours after delivery), after cold applications had been used to the abdomen, &c. I found the patient very much sunk, and there was a constant gradual loss, threatening syncope. From this time I scarcely quitted the house until she died ; for although the loss was slight, and plugging the vagina—cold—ergot, were used, as well as stimuli and nutriment administered when the syncope became alarming, there was no rallying ; and in spite of every effort to save her, she died within 48 hours more, or above three days after delivery. What caused the gradual loss, or what be-

* Her losses were profuse even before marriage. I once saw her, 20 miles off, in apparent danger from menorrhagia at the menstrual period.

sides the loss depressed her vital powers so fearfully, I know not. No *post mortem* took place, nor did I introduce my hand into the uterus when I found threatening syncope, because the loss was slight, 48 hours had elapsed, the uterus (particularly the os) was contracted, and it was ascertainable that the uterus was not distended with blood. Perhaps there might be disease of uterus accounting for a gradual oozing; besides, from the time I saw the patient (5 p. m. on Saturday, when she was apparently well and cheerful), there might have been greater loss than I was aware of previous to my being summoned at one next morning. The menorrhagic tendency of this patient was remarkable, and the case further conveys an impressive lesson by affording an instance of a patient being apparently quite well 28 hours after a regular labour, and dying subsequently from gradual loss.

Case 127.

Mrs. ——, æt. 30. After a slow labour (second) bleeding followed the delivery of the placenta. The patient fainted, and I was summoned by the surgeon in attendance. A piece of ice was placed *in utero*—the patient rallied after a short time, and all did well.

Case 128.

A lady, about 25 years of age, after a slow but natural delivery (third) had hæmorrhage shortly after the removal of the placenta, and became faint. I was summoned six hours after the birth of the child, but no faintness or loss occurred after I arrived. I waited two hours—no loss—the patient gradually rallied, and recovery followed.

Syncope.—Case 129.

Mrs. N——, third or fourth pregnancy; had a cough, which much reduced her; in this bad state of health, perhaps verging upon a consumption, she arrived at six or seven months of utero-gestation—was taken very faint at 10 a. m. March 30—gasping, and with scarcely a perceptible pulse—this continued. Her accoucheur examined and found no signs of labour; but at 4 p. m. labour had advanced—he ruptured the membranes—found a breech presentation. As the fœtus descended, he hooked his

finger round the groin and assisted its delivery—the placenta soon followed. I was called at 10 p. m.; found the patient in a gasping dying state of syncope, with jactitation—cold extremities—leaden hue of countenance—pulse only just perceptible. There had really been no external hæmorrhage; only two or three napkins soiled; no large coagula; the placenta having as little blood with it as is seen in one of any twenty cases. Still there was an oozing of florid blood from the vagina. Warmth, stimuli, and opiate internally, and plugging vagina, were the means resorted to, without effect. The patient died an hour after I was summoned. My explanation of this case, theoretical, however, and not demonstrable, is, that the placenta partially separated in the morning, giving rise to internal hæmorrhage enough to produce syncope in so feeble a patient; and that the patient really died from bleeding into the uterus, though there was no external bleeding. Her symptoms were exactly such as occur in syncope from hæmorrhage. The still-born fœtus died, I presume, in the morning (which the separation of the placenta would occasion), as it was believed to have been living shortly before. When I arrived, I should say the uterus was not greatly distended; still it might contain a pint or two of coagula no doubt.

I was present at the examination of the body—the patient was really not greatly emaciated. The lungs were unusually sound; if in any way morbid, it was from a preternatural quantity of mucus in the bronchi, which might have occasioned her cough. The uterus was well contracted, and contained not an ounce of coagulated blood—the liver was very large, though not otherwise presenting any morbid character. This woman was greatly depressed in spirits for some time past, and felt convinced she should not survive her labour—beyond this, I really can offer no sufficient reason for the fatal syncope further than to say, that in a person so depressed in spirits, so desponding, the loss of a small quantity of blood was sufficient to produce the result. The heart as well as all other organs of the chest or abdomen were healthy—much blood in the right side of the heart and in the large veins; also much venous blood in the liver and kidneys. One portion of lung, I omitted to state, was hepatized from disease, not from depending position.

CASE 130.

Mrs. B——, a very feeble and delicate little woman. The membranes broke five weeks before delivery, followed by a great loss of water; and daily afterwards she lost water by a sudden gush, and not a constant dribbling, which I could explain only by supposing the membranes had broken near to, but not directly opposite, the os uteri; and when the membranes became re-distended, a fresh gush ensued. So much water was lost day by day for five weeks, that the liq. amnii must have been repeatedly secreted afresh, or all would have been so passed away, leaving the fœtus and membranes only in utero; and this constant excretion I expect still further enfeebled the slender powers. The labour took place favourably, a vigorous little boy being born within an hour after my arrival; before he was born, I apprehended syncope, and gave the patient a little brandy and water. After its birth, there was considerable loss—the placenta was not expelled in a quarter of an hour—I proceeded to remove it, for syncope had come on—it was so soft that I removed it piecemeal but completely, aud supplied the patient every few minutes with gruel and brandy—no loss after removal of placenta; but she lay for six hours without a perceptible pulse—a pallid deathlike countenance—incoherent talking—tossing about. Animal broth with wine was given in small quantities every few minutes—the pulse was again just perceptible, but was lost afterwards for two or three hours more, and I thought there was no hope—the patient tossing, refusing drink, and with a determined push driving the cup away when offered; but at above ten hours from delivery, the pulse was again perceptible, and she gradually rallied—became cognizant and collected. What is singular, there was no reaction—no flushing of the cheek, though brandy and wine had been taken by a delicate weed of a patient, who ordinarily took no stimulating drink. It was four days before she rallied so as to move herself at all in bed, being lifted whenever a change was required; the bowels were relieved by injection, and purgative medicine avoided.

In this case had I not well distinguished, but followed the too usual course of open doors, cold air and cold moist applications to the body, the patient must surely have been lost.

Nov, 19. Ten days from labour, the patient is quite rallied—

takes food well, and is raised up in bed to eat her meals—the breasts have never filled, the child being kept away. After this, a speedy recovery.

Case 131.

Mrs. R——, æt. 23. Kept by a married man—has one child above a year old—her mother in attendance, from whom she concealed her situation, and passed for married, using a feigned name. She went on well for five or six days; then came on sudden depression and faintness, as if indeed she were threatened with entire syncope and death—pulse slow; then intermitting. Two medical men were called on the urgency during my absence, and both prescribed stimuli, ammonia, æther, and brandy. I gave the same, with wine, and during a second night I was throughout in attendance in the house, seeing her every two hours. For several days a most distressing and even apparently dangerous depression continued, and no sleep was gained in spite of opiates—the fainting was most on awaking, and also in an evening. Porter was given freely, and after several days of jeopardy all was set right; and Dr. W——, who was called in, was of the same opinion as myself, that moral causes produced all this evil. The pulse were never quick, but there were at night profuse perspirations consequent on the worst attacks of depression. She recovered, and I believe mental impression or depression to have been the great cause of all this trouble.

Case 132.

Mrs. E——, æt. 32; her sixth pregnancy; a delicate emaciated woman, having had many children in quick succession.—Although after delivery, there was no extraordinary loss, and severe after-pains came at intervals, she was so faint that the pulse could only just be felt. I gave from 3 to 4 oz. of brandy, remaining with her 5½ hours before she was sufficiently recovered to allow of my leaving her for any time; and even after brandy had been given freely, the pulse became imperceptible, lips pallid, and I was in much alarm—feet were cold—I had them rubbed and warm flannels applied—the patient became restless, and wanted to change her position to take off the faintness—called out to have the faintness prevented—most alarming symptoms.

This was no case for open windows, chilling air, cold ablutions; but syncope determined by feeble powers of life, under a moderate loss of blood.

Case 133.

Mrs. ——, in her second, third, and fourth labours, had hæmorrhage after delivery and syncope. It usually came on two or three hours after delivery. Her first was a face presentation; her third, a breech. In this, her fifth, it was a breech; but on account of long delay, I brought down the feet—found a narrow pelvis from projecting sacrum—delivery was therefore slow, and the child irrecoverably still-born. Syncope came on and continued five or six hours; the loss was not profuse, but the blood poor, thin, giving a watery stain, and having little crassamentum. She rallied after a time, and there was not a recurrence of severe syncope, although she continued very feeble, and was not able at a fortnight's end to quit her bed.

Hysteritis—Puerperal Fever—Peritonitis.

Hysteritis.—Case 134.

Mrs. R——; fourth child—good health—had an excellent time. On the 3rd day, rigor, followed by pain of the thighs, then of the uterine region, and soon reaching the loins, when it was so distressing as to make her scream, and aver that it was worse than a hundred labours—pulse 120. Within two or three hours of the commencement of the attack, I met Mr. R—— on her case. I bled directly to faintness—next had a hip bath. The first measure gave great ease; the bath was also serviceable—plentiful purging with calomel, colocynth, and salts, followed in the course of the night. Mrs. R—— soon did well—there was no coagulum passing, nor anything to explain the pain, but the presence of uterine inflammation, which I believe it to have been. Pulse 130 the following evening, and the fever great, but all went on well after that date.

Case 135.

Mrs. G——, under 30 years of age; first labour; child born with large spina bifida of loins. On the third or fourth day after

labour, rigor and pains—the latter abated by bleeding, &c., and she seemed to be doing well; but the symptoms returned in two or three days more, and ten days from her labour I was called, and found her in a hopeless condition—heaving, whispering breathing, pulse fluttering, and 130—no pain, quite easy, and even cheerful—abdomen tumid and most elevated in the centre. A second bleeding, leeches, huge blister, and free purging had been tried. Mr. B—— observed that at first the pain was in the uterus, where he had no doubt the inflammation commenced. I gave a mixture of turpentine with opium, which was retained.—She died in 30 hours. No examination permitted.

Case 136.

——, æt. 18½ years; first labour. A feeble male child born on Sunday, April 17th, which died in five days. For two days all well; pain and some difficulty in passing water—catheter once used; free purging.—Thursday. Acute violent pain in the region of the uterus; then V. S. performed; pain relieved; water passed better; rapid pulse. I was called on Friday; pulse 130; small; spoke whispering; tongue dry and brown in the centre; frequent small mucous evacuations; some straining and tenesmus vesicæ on passing water; no pain; body nowhere distended; laid on her back, but could lie on her side. My treatment was, opiates; bland nourishment; mild tonics. Next day, cheeks flushed; hurry; tremor; pulse 140; still liquid motions; urine scanty and high-coloured.—Sunday, tongue moist; more food taken; pulse 150; bowels quiet; body fuller, still not prominent. I thought there was some improvement; but with such a pulse, what security? This lady died at 6 a. m. on Thursday, 28th.—That inflammation of the uterus had been the cause, I doubt not; but the abdomen did not become large and pyramidal, as if general peritonitis ending in effusion were present.

Case 137.

A fine jolly healthy young woman, had a natural, regular, and not very protracted labour; first pregnancy. I could not learn that she committed any error in diet. A rigor came 30 hours after labour, and two hours after this, I found her feverish,

with pulse 120; great pain in region of uterus, which increased at intervals; large bleeding performed from the arm; purging medicines freely given with some effect upon the bowels. Pain increasing; 20 leeches at midnight, with relief, followed by a large blister. Next morning, I bled largely again, but the pain was only checked for a brief period, to return more violently. In the evening she was sinking; abdomen tumid, though in the morning it was not so, and pressure every where was well borne, except in the region of the uterus. She died before morning; 36 hours after the rigor; 66 hours after delivery. No inspection permitted.

I took this for a well-marked case of puerperal fever, commencing in inflammation of the uterus. The diseased conditions, with fever, ensuing after labour, and designated by the general term of puerperal fever, are the following:—1. There may be peritonitis, generally commencing in the peritoneal covering of the uterus—and even this occurs in two states—one with violent pain and a good system as to stamina—the other with a feeble system, very little pain, rapidly destructive, the abdomen soon getting tumid, often preceded by flooding at the time of labour. —2. Inflammation of the uterus itself—its substance; here though pain is constant, it is increased at intervals, similar to labour or false pains, shewing that it is situated in the uterus.—3. Fever with great debility; small rapid pulse; tenderness only in the region of the ovaria; the body bearing pressure. It is inflammation and ulceration, &c., of the sinuses of the uterus; the abdomen here becomes tumid after death.

Case 138.

Mrs. ——, æt. 19 years; first labour; was delivered, after an easy time, at 8 a. m. May 7th. In the afternoon, had severe pain of the uterine region; was very pallid; pulse 120. Mr. H—— bled very largely—and when I arrived at 8 p. m., the patient was faint; deadly pale; pain less than before; pulse under 100. I assented to mustard poultice to the abdomen, and cal. with opium; but know not if i were decidedly puerperal inflammation beginning about the uterus, but checked by immediate treatment. This woman did well.

PUERPERAL FEVER.—CASE 139.

Mrs. H——, æt. 32; seventh pregnancy; was low, nervous, suffered much from pain in her body and distention during the whole of her pregnancy; described herself to have all sorts of pains and feelings, and was very desponding. Her labour was regular and quick and seemed well over—child very large. After the first five or six days, which seemed to pass on well enough, she complained to me that she could get no sleep at night; had hardly slept during her confinement, which was actually the case. I gave an anodyne, which obtained some sleep; but she was hurried and anxious, though free from pain, except when she sat up, when there was pain somewhere in the region of the uterus, but she did not know where. The bowels were again well opened by castor oil. At the end of eight days, the pulse rapid, small, 120; great prostration; heaving of the breathing; body bearing pressure; tongue patulous, very red, covered with a loose fur, pimply edges. There was such a loss of power, and a good-for-nothing pulse, without obvious local disease, that there seemed little to be done. Opiates gave relief, and at night obtained sleep. Quinine could not be borne. There was daily an exacerbation of fever in the afternoon. On the 10th day, pulse 140 in the morning; the body bore pressure, but seemed rather full. In the afternoon there were flushed cheeks, hot skin, succeeded by cold clammy perspiration, and a pulse 150. Next morning she died. Permission was not granted to examine the body.—Is it not likely there was disease about the appendages of the uterus, perhaps in the sinuses, giving rise to the symptoms of depression, fever, exhaustion—and producing death?

CASE 140.

Mrs. B——, æt. 34; first pregnancy. The surgeon who attended her tried twice to apply the forceps without succeeding, and I was called 24 hours after the os uteri had been fully dilated, and as long after he had first attempted to apply the forceps—head low, and I applied the forceps readily; and with a few pains a large male child was born: but I found the labia hugely swollen, ædematous, and tender; the sphincter ani relaxed, and the anus protruding and swollen. I understood she was going on

pretty well, but on the 12th of July, being a week after delivery, I was called; found the patient had been unable to stir for some days, owing to pain in the lower part of the body, and more especially in the back—body tumid—urine had flowed into the bed—hips and labia excoriated, and the latter greatly swollen as when I applied the forceps—pulse quick but full, unlike the small pulse of puerperal peritonitis. Perhaps in this case the uterus was the seat of the mischief—breasts flaccid—lochial discharge had been good, is now small in quantity. V. sect. ad ℥xij. cal. et op.—Blister to abdomen; she had been purged. It was with difficulty we could lift her up by the thighs, to get clean linen under, so great was her fear of moving; and nothing could induce her to turn or be turned on one side. An erysipelatous blush extended to the hips and loins—the labia excoriated and sloughed—vesications took place on the outside of the hips, and the patient, though in a state of ease that deceived her attendants, had a furred tongue, conical abdomen, rapid small pulse, and died on the 15th of July.

Case 141.

Mrs. P——, mother of six or seven children. Seven years ago, when three months gone in pregnancy, she had stoppage of water; her surgeon could not introduce a catheter; at length the water dribbled away, and after two or three weeks of suffering, she got right, and went to the full period of gestation. Since then she has thrice borne children and had good times, the child often born before Mr. —— got there. She is now three months gone, and was unable to pass water all the night of Saturday.—Sunday, May 18th, Mr. —— was called. Great agony suffered; distended bladder; could not pass a catheter; bowels relieved by medicine. On Monday morning I was called; could pass a male flexible catheter in 7 inches at least, and no urine flowed; but after repeated trials, I directed a female silver catheter more forwards (the patient lying on her left side, and my left fore-finger in the vagina, directing the course of the catheter), over the pubes, and evacuated 3 pints of urine; the instrument reached the bladder at 3 inches. The patient was, when I went, in great pain; the bladder to be felt distended; she strained violently from time to time, and then there was a gush of a tea spoonful of urine from

the bladder. Both by the rectum and the vagina a large tumor was felt, enough to fill the pelvis, and confirming my suspicions of the uterus being retroverted. I could not feel the os uteri, pushing my finger to the utmost immediately behind the symphisis pubis. No uterine discharge of any kind, but straining bearing-down pains from the first, such as to excite a suspicion of miscarriage. I could not but believe that the urethra was torn, and that the catheter went out of its right course, though where to I could scarcely conjecture—not into the peritoneal cavity, for no symptoms were present nor afterwards followed to indicate it, in pulse, stomach, or tenderness of abdomen—perhaps it went into the vagina higher than I could feel, and then found a way by the os uteri. Attempts were made, by pushing up the fundus, to replace the uterus, but without success—it was probably ædematous where I touched it, as Bard and others have mentioned to be the case, and that would account for the greater size of the uterus. The catheter was kept in several days, and then a flexible one kept in. Ten days after, the tumor had the same situation; in a fortnight the catheter was removed to try if the water would pass. She went on in utero-gestation regularly afterwards, and groaned in the following November. The labour had gone on slowly, and Mr. —— was in the way all day, but rode into the country in the evening, and I attended in his absence; the child was born before I got there, and great flooding had taken place, the blood flowing down to her heels. The placenta soon separated. I found the uterus afterwards well contracted; no flooding after the placenta was away; the patient was not faint; pulse good; I left her and did not see her again, but learnt from Mr. ——, that in three or four days, there was fever; alarm excited; Mr. —— called; body not tender but throughout bearing pressure; no pain complained of. Dr. —— was subsequently summoned; all thought there was no peritonitis. On the 9th day she died.—Was there no inflammation of the large sinuses of the uterus? Is not such a state accompanied by low fever and little pain? Does it not occur more frequently where there has been great hæmorrhage during labour?—No bleeding was practised on this patient.

Case 142.

Mrs. C—— had three or four children, but not any for the

last four or five years, until Mr. —— attended her on the 26th of July, when a healthy girl was born. I saw her on Wednesday, August 1st, five days after her labour. The following were the symptoms I observed :—No lochial discharge ; tremulous pulse, beating 120 in a minute ; frequent sickness and vomiting ; no peritonitis. This mischief had arisen insidiously, without any acute symptoms, and I could but consider it a case of uterine phlebitis, sure to prove fatal. The treatment consisted of calomel and opium ; blister ; fomentations ; but a fatal termination quickly supervened.

PERITONITIS.—CASE 143.

Mrs. ——, mother of five children ; attended on Wednesday, April 14 by a midwife, in her 8th labour, which was quickly over. On Thursday she was so well that she got up ; never was so finely after any accouchement. At one o'clock on Friday morning she was taken with a cold chill, which she called an ague fit ; this was followed by pain in the body ; at 11 o'clock a. m. I saw her ; an apothecary had just been with her, and directed an opiate pill and port wine and water. I found great pain and tenderness of abdomen ; pulse small and quickened, and every symptom to excite alarm ; gave cal. and jal. and bled from the arm moderately ; at night a blister. Saturday ; there had been plentiful purging lochial discharge, which had been interrupted, returned slightly ; no relief to the pain ; in the evening pulse 150 ; and continued at that rate through Sunday and Monday ; cold sweats ; relief to pain, but deceitful. Tuesday, picking of bed clothes. Death in the evening, less than five days from the commencement of the attack by cold chill.

Examination.—Abdomen about the umbilicus elevated from distension of the small intestines with air ; a pint or two of yellow fluid in the peritoneal cavity, with numerous yellow straw-coloured flakes of lymph ; small intestines glued together universally by their peritoneal surfaces ; omentum reaching down within a few inches of the pelvis, was equally glued to the intestines, on which it rested, and to the peritoneal lining of the abdominal parietes. The omentum was also thickened in its substance, so as to look fleshy, and almost deceived me at the first view of it ; the lymphy effusion was most upon the small intestines ; little

upon the peritoneal surface of the uterus, and still less upon the viscera occupying the superior part of the abdomen. The uterus (6½ days after delivery) was as big as my two fists; its walls from ½ to ¾ of an inch in thickness; its cavity containing only a little sanious substance adhering to its internal surface; at one part the internal surface was rough, irregular, and to this I believe the placenta had adhered; neither the cavity nor substance of the uterus indicated that organ as concerned in the disease which proved fatal, and the peritoneal coat of the uterus was only slightly covered with the yellow lymph; the ovaria were solid and pale, but the fimbriæ of the fallopian tubes were enlarged into bundles of red vessels, so as to look fleshy, like those of quadrupeds when fit for or just after impregnation. The distended small intestines were pale, and nowhere were vessels visible on the peritoneal surface; the large intestines were not distended, and their peritoneal coat less covered with lympth than the small. I know not what could have caused the disease, unless the imprudence in getting out of bed the day after delivery. I thought of Dr. Brennen's turpentine remedy, but did not try it. An ignorance of the nature of disease is the principal cause of the boldness of quacks, and the confidence of the public. After effusion has taken place on the peritoneal surface to the extent here noticed, nothing but blindness to the state of disease could lead any one to hope for or expect relief from turpentine or any other medicine.

Case 144.

Mrs. B——, æt. 27; has had two or three children before Mr. —— attended in her present labour; child born before he got there, but he attended to the expulsion of the placenta; 24 hours after, she had pain in the abdomen, and was bled and purged. I saw her when seven days had elapsed; no lochial discharge since the first day or two; breasts flabby and empty; body bore pressure except on the right side; she was torpid and sinking; pulse 110, and as it had some force, I did not apprehend immediate decease—she died in 12 hours. The body was examined—an abundance of wheyey and curdy fluid was found in the peritoneal cavity; the bowels every where glued together, and inflammation of the peritoneum so universal, that the liver was

covered with lymph; the uterus was not inflamed in its substance.

CASE 145.

Mrs. —— aged 35; fifth pregnancy; her former labours had been quick; in the present instance she had a severe labour lasting 10 hours, owing entirely, I believed, to the child's head being large; whilst she was groaning in the middle of the day of August 7th, I left her, and assisted at the dissection of an hospital hemiplegic patient, dead of erysipelas. Delivery took place about 3 p. m. I had used my fingers in stretching the os uteri, because it was slow in dilating; and it has occurred to me, that when there is a tendency to erysipelas, a slight rent in the os uteri might be the wound where such a disease might take its origin and proceed. At four on Sunday morning, just above 36 hours after labour, I was called, Mrs. ——, after sleeping soundly, having awakened at two with pain on the left side of the abdomen; the pain had increased when I got there—she had already taken castor oil. I remained three or four hours; found the pain increase, and the tenderness extend upwards and to the right across the body. She had been feeble during pregnancy, and I would not bleed, but directed leeches and hot fomentations to the abdomen. In the afternoon I had a consultation with Dr. ——, the patient's countenance looking sharp and anxious—pulse rapid—the pain continuing so as to alarm me, and extending so as to occupy the lower half of the abdominal region. A glyster was given—bowels well active—one moderate bleeding—then we had recourse to opium—a large blister to cover the abdomen. She died in the course of Monday, living little more than 36 hours after the first attack, thinking herself better for some hours before she died, owing to the subsidence of pain; but her heaving breathing, swollen abdomen, and diminutive pulse, indicated what must soon happen.

Examination.—Only 5 or 6 oz. of serum in the peritoneal cavity—a few flakes of lymph—the peritoneum at the lower part of the abdomen was very vascular—the substance of the uterus was not at all affected, but pallid—the cellular tissue between the peritoneum and the abdominal muscles was, at the lower part of the abdomen, between the pubes and the umbilicus, infiltrated with a wheyey serum, which could be collected by scraping with

the scalpel; and it was clear that the cellular structure in this region had been the seat of disease as much as the peritoneal surface. What was the connexion between this case and the erysipelatous dissection at the hospital? is a question I must weigh well before I can answer.

Case 146.

Mrs. Y—— had a good regular labour. I examined once and left her, finding the os uteri moderately dilated, and when I was re-summoned two hours afterwards, the child's head was at the os externum; and with two or three pains a very fine boy was born at 7 a. m. of the 3d September. The next morning, at 10 o'clock, she expressed herself well—had suffered moderately from after-pains, and slept well with two ½ grain opium pills; her face was of the healthy rosy hue usual to her, and cheerful. An hour after I left, she had a rigor, and pain commenced in the region of the uterus. I saw her before 2 o'clock, when the pain was so bad she was calling out from it, and described it much worse than her labour pains. I bled her half a hand-basin full, at least 30 oz., and until she felt faint, which abated the pains for an hour; but they returned with greater force. Pills of cal. and col. were rejected, so I gave 5 gr. calomel pills every half hour, till ℈ij had been taken. In the evening, pulse small—countenance pale—pain diffused over the abdomen, even so as to check breathing. I ordered 36 leeches—24 only were applied to the abdomen—a glyster. During the night, a mixture with ol. ric. ℥j, and sp. tereb. ℥ss taken, and a blister applied, which nearly covered the abdomen; nine or ten motions before morning—still on my visit, 5th September, though bleeding, leeching, purging, ℈ij calomel, with castor oil and turpentine, had been tried, all within 24 hours from the commencement of the pain, the disease was going on. Her pain had all along come severely at intervals (though never absent entirely, and always tender to pressure in the seat of pain), so as to make her scream out—and this shews perhaps that it commenced in the uterus—if in the peritoneal covering of the uterus, then the contraction of this organ, as in after-pains, would be more painful; altogether this occasional increase of pain may be said to indicate that the disease begins in the uterus, and the situation of the pain assists.

Sept. 6th.—She got no rest last night—is pallid and sunk—pulse 130—abdomen full and raised, but the pain is much diminished, and has been since yesterday noon; the pulse and countenance contraindicate a favourable change. The lochial discharge has nearly ceased—she lies on her back, knees not drawn up—could not persevere in taking turpentine, so has a powder with sulph. and carbon. magnes. Last night, after profuse purging 24 hours, I gave two pills of cal. and opium, each ½ gr. In the evening, she was easier and could bear pressure on the body, which was not full and tense, but soft—a little prominent—her pulse however varied from 140 to 160, and there was no hope. She died next day, Sept. 7th. Examination not permitted.

Case 147.

The lady of ———, aged 28; has four living children; and the following fatal history is connected with her fifth pregnancy, in which she was advanced 7½ months, when, on Friday morning, Nov. 16th, she shewed signs of premature labour. Mr. —— was called—there was bloody loss going on—in the course of the day he ruptured the membranes—the loss was very considerable, so much so that cold applications of vinegar and water were largely used. The labour, I believe, was not terminated till next morning (Saturday, 17th)—child dead. In the evening of this day, there was affection of the larynx to such a degree, that Mr. —— considered it croup, or acute inflammation of the larynx—cough, dyspnœa, whistling breathing, loss of voice, tenderness on pressure upon the region of the larynx. The symptoms were so threatening of suffocation, so urgent, that besides leeches to the throat, bleeding was practised freely from the arm; also a blister to the throat. This was, I believe, the state of the disease throughout Sunday, 18th; and on Monday the larynx got better. The patient was greatly reduced—but acute pain was felt in the right hypochondrium. Again bleeding from the arm—a few leeches applied—a blister on the affected side. Dr. —— was called, and attended late on Monday evening, when he sanctioned a repetition of the bleeding—and altogether four bleedings from the arm were practised, the last only to the extent of a few ounces. In the course of Monday night, the patient was so exhausted, that although the laryngeal attack was subdued, and

pain in the side slight, she was thought to be sinking. The abdomen became greatly tympanitic, much flatus and rumbling of bowels—hiccough. Still on Wednesday morning (21st), the patient, having taken a little wine and broth, rallied. Mr. ——, who was not much experienced in such cases, buoyed up the relatives with hopes of recovery. Purging from medicine taken occurred on this day. I was called, and arrived at 10½ p. m. on Wednesday, 21st. I soon became convinced that there had been general peritoneal inflammation, and that the patient was in the last hopeless stage of puerperal peritonitis. The patient had for days laid upon her back, unable to bear the lateral posture, and the pulse were varying from 130 to 140, and most feeble—most diminutive—the countenance was sunk and anxious; yet not much suffering complained of—the body not very tumid, the tympanitic state having diminished since yesterday. (I should have observed, a blister had been put on the abdomen, being the third blister, and the legs had been vesicated by mustard cataplasms). Motion and urine passed in the bed on napkins, and great anxiety was expressed by the patient, as is usual, about the passing of motions, the mind dwelling much upon that object. The patient had slept two hours, after an anodyne, just before I arrived, being the first sleep experienced by the patient, I am told, of any continuance since she was delivered. Sleep did not return—for the 7½ hours I remained, the patient lay usually muttering and wandering, though sensible when roused. Here were symptoms combined to preclude all hope; and only ignorance of such cases, and confiding in the absence of pain, could lead to any favourable opinion being expressed. Animal broth, milk gruel with a little brandy, were what I advised, with the repetition of a few drops of sol. acet. morph. at short intervals. I left at 6 a. m. of Thursday, 22nd, and the patient died at 6 p. m. of that day.—Mr. —— spontaneously remarked to me, that the cold applications he feared, though he had the best authority for applying them in such a case, had determined the laryngeal affection; and Dr. —— subsequently made the same remark to me. I have a horror of these cold applications under such circumstances, independently of their being so imperfectly applied as to be alternately hot and cold. Where there is active hæmorrhage, and the patient warm or heated, as is often the case at the beginning of

such a case, I would cool the air, lighten the bed-clothes, remove some, lift up others, and make sure to fan and cool the surface of the body—producing a refreshing coolness, removing accumulating heat, and such as may be conceived to increase the hæmorrhage ; but cold moist vinegar cloths to the abdomen or labia, which in three minutes, however cold when applied, get warm and are removed reeking with heat—or a douche upon the abdomen, as some have advised—are measures I have never myself of late, of many years, adopted. I assert that they are continually applied so imperfectly, that they become the reverse of what was intended ; and when converted to hot cloths, increase the very evil intended to be removed—but a great objection lies in the violence thus done to the system, driving the circulation elsewhere, determining affection of the head, larynx, or other part of the body ; or by re-action (on the cessation of their application), leading to increased action in the very region to which they have been applied.

Some few years before this occurrence, and unconnected with labour or pregnancy, Mrs. —— had dangerous inflammation of the wind-pipe—but it was subdued, and instantly there arose inflammation of the liver. This lady was a plump, jolly woman ; addicted to dining in company, and rather high living—subject to attacks of local inflammation—once since she began to bear children, she was seriously attacked with laryngitis—in some of her former labours also she sustained great loss from hæmorrhage.

How much has method of living, free and luxurious diet, to do with child-bed diseases ? even more than temperament. Mrs. E——, whilst the wife of a thriving merchant, living in luxury, feeding freely, indulged in every thing, and taking little active exercise—had, successively, labours complicated with convulsion, hæmorrhage, mania. But her husband a bankrupt, the cares of a large family, narrow diet, herself obliged to be active, hardly a servant in the house, she continued to have children, and 1, 2, 3 labours passed without fever or any complication.

Mrs. R—— had frightful suffering—hæmorrhage—convulsion —mania—inflammation of the brain—peritonitis. After reverses, a labour healthy and uncomplicated.

Women indulge much in feeding, and follow their inclination without restraint during pregnancy ; often laying the foundation

of puerperal disease in this way; and if you would treat them with success, and have labour uncomplicated as to inflammations, convulsions, mania, &c., you must guide them during utero-gestation in regard to diet, exercise, &c. It is surprising how little nutriment supports the system in this period; the reverse of the time of suckling a child, when ample nourishment should be urged.

As to cold in hæmorrhage, you should rely on cool air, diminished covering, fanning; cool the surface of the body generally; do it judiciously but effectually; in a way that is refreshing and agreeable—stopping your measures when the system is cool, and not going on to freeze a bloodless, lifeless, sinking patient.—Watch well the period when you must change for a little stimulus; and there are cases of atonic hæmorrhage, when you must not apply cold at all. If cold be admissible, and with a view to stimulate a relaxed uterus to contract, it should be iced water, or salt and water, in a bladder, laid over the uterus.

I have seldom felt more for a wretched maltreated patient, than when, on going into a freezing room with open windows, I have found her drenched in wet cloths, with cold extremities, deathly pale countenance, a pulse almost extinct—the hæmorrhage actually stopped; and the sufferings of the patient, and her danger from its past influence aggravated by the injudicious continuance of measures which could only retard, perhaps prevent for ever, her rallying. Est medium in rebus—the refrigerating system has been so powerfully impressed upon practitioners by teachers and writers, that nothing else, no other resource, I have often had occasion to note, seems appreciated or recollected.

Case 148.

Mrs. C——, æt. 29; first labour; attended by Mr. G——; full term. Mr. —— had been present nearly 18 hours when I was called, and had introduced both vectis and forceps; the latter would not lock, and he could not succeed with instruments. I was requested to take my instruments, as the head might require to be opened—the child's head lay at the brim of the pelvis in a normal position—the os uteri was not very amply dilated, so I deemed forceps scarcely applicable; and as the child might still be living, and the pelvis was not deformed, not very narrow, I advised

waiting four hours, when I agreed to attend again; my impression was, that instruments had been used too early. Before the four hours were expired, I received a report that progress had been made, and that I need not attend; but at night, eight hours from my leaving, I was re-summoned—found the patient's pulse rapid—child's head scarcely altered in position, though the os uteri was more open, and I assented to perforate; this Mr. —— did, and in about an hour the fœtus was extracted.

Next day, May 17th, there were indications of severe peritonitis—vomiting—great pain in abdomen—bleeding was freely performed, by leeches largely to the abdomen, as well as once from the arm—blisters—cal. gr. ij. c. opio. every two or three hours—very frequent sickness and vomiting of a greenish fluid—and towards the latter stage, the use of liquid opiates was required to relieve pain—the body became very tumid and conical, and she lay throughout on the back, with the knees drawn up. Death happened 5½ days after actual delivery. On inspecting the abdomen, we found the bowels united by lymph—serum in the peritoneal cavity—lymph largely present even about the liver, so general was the peritoneal affection, and not partial about the lower part of the abdomen—there was also yellowish serum in the anterior mediastinum, shewing the inflammation to have extended there, and the pleura of the left lung was glued to that of the chest by recently effused lymph. This is the only instance I have seen of puerperal peritonitis extending to the chest. Early in pregnancy this patient had been treated for severe pleuritis of the right side of the chest, and here the lung was found very generally adherent from that attack, and no signs of recent inflammation of the right pleura were present. No particular disease of the uterus, which was small and more contracted than I have before seen it so soon after labour. The os uteri and contiguous part of the vagina was dark and sloughy, but the slough did not extend to any great depth. I suppose the frequent use of instruments had caused this, but there was less mischief than I expected or than often happens; and the peritonitis was the cause of death.

Case 149.

Mrs. S——, æt. 23; second labour, and a regular time;

delivered on Saturday, early in the morning; pains of the abdomen in the evening, preceded by rigor, which required bleeding from the arm, leeches, and purging, successively. I was called in on Monday, at 11 a.m., and found a tumid abdomen—fixed dorsal position—much purging—anxious pale countenance—small pulse at 120. I saw the last stage of a hopeless case of puerperal peritonitis, and could only advise nourishment, and an opiate injection to stop the purging. The patient died the same night.—No inspection of the body allowed.

Case 150.

Mrs. J——, mother of six children. In her last pregnancy she was ill, and took advice for great sickness and pain at the upper part of the abdomen; was confined on Saturday, June 30th, under the care of Mr. ——. On the third day she ate meat rather freely; soon shewed fever and constant sickness, and Dr. —— was called. The treatment consisted of a blister, calomel and opium, and aperients. I was summoned on Monday morning, July 9th, and found the patient lying on her back, inclining to the right side; respiration short and quick—pulse 120—tongue moist—pain in left hypochondrium, with inability to lie on the left side—surface of the body cool and clammy—frequent sickness. I advised fomenting the body, giving brandy and water, &c. She died in 20 hours from my first seeing her, and, I believe, from puerperal peritonitis. No *post mortem* was allowed.

Phrenitis.—Case 151.

Mrs. ——, æt. 29; first labour; dead child. She had inflammation of the brain a few days after delivery; and when I was called, after several days continuance of the attack, she was pallid, emaciated, comatose in a degree, and could not speak, but could put out her tongue when requested. Required the use of the catheter twice daily. She had been treated very actively—bleeding—shaved head and cold applications thereto—blister to the nape—mustard poultices to the ankles. I thought that the moderate influence of mercury, economising the powers, and getting down a little mild nutriment so as to sustain them, offered the best prospect in this almost hopeless case; and 10 or 12 days

after my visit, I learnt that she was daily improving. This promise was not realised, for she died soon after.

Diffuse Inflammation of the Cellular Tissue of the Pelvis.

Case 152.

Mrs. ——, æt. 30; first labour. She had been well during pregnancy, although not particularly strong, nor robust. The labour was by no means protracted—she bore it well—and all terminated in the most natural way, the child being born about two a.m. on Friday, the 8th of March. I did not see her till one p.m. on Saturday, the 9th—water had been passed after labour—she was particularly well and cheerful, so much so that I felt reason to caution her to keep quiet and adopt every precaution, that she might run no risk of inducing any evil—the body was free from all tenderness—the only circumstance to be noticed was, that her pulse was rather quick. At five p.m. this day, she passed urine, and afterwards gave suck to the infant. At eight p.m., a severe rigor, followed by a fever fit, under which I found her labouring when I arrived at eleven—skin hot—pulse very rapid and small—face rather flushed—she lay on her left side. I could press the abdomen generally without causing pain, except exactly in the region of the uterus, which was the seat of a degree of uneasiness she could not clearly define or describe—pulse so small that I dare not use the lancet, but directed 10 leeches to be applied directly in the uterine region, and six more to be subsequently applied if she bore the loss of blood well, and was still not enough relieved of pain. There had been a good alvine evacuation in the evening. I directed cal. gr. ij. with opium every two or three hours. At four a.m. of Sunday, I was with the patient—found the leeching had induced extreme faintness, almost syncope—this resulted from the first 10 leeches; but as the patient rallied after an hour or two, four more leeches had been applied when I arrived. I found her quite pallid—pulse very small and 130; restlessness—some uneasiness over the uterus, but not in the rest of the abdomen. I used the catheter, as no water had been passed for 12 hours; but there were only 2 or 3 oz. of urine, the kidneys having secreted very sparingly. I

took the most alarming view of the case, and in the course of the day Dr. —— consulted with me ; this was at four p. m., and we found pulse 140—the patient now began to be fixed on the back, preferred having her knees drawn up—was faint and pallid—vomited. We persevered with cal. and opium, and allowed a little ammonia, and even wine and water. The abdomen became very prominent, tympanitic, conical; and death happened at two a.m., being 30 hours from the rigor which ushered in the disease, and about 70 hours after labour.

P. M. Examination.—The intestines were pallid, and the peritoneum generally free from all inflammation—five or six oz. of serum in the peritoneal cavity, nearly transparent, and no lymph or muco-purulent fluid. Beneath the peritoneum, in the reticular texture of the pelvis, where the peritoneum is reflected from the uterus to the pelvis and abdominal parietes, there were several ounces of clear lymph effused, like the contents of a blister when viewed through the peritoneum ; and cutting through the peritoneum, I collected several ounces of this as it issued from the reticular tissue of the pelvis and neck of the uterus—this seemed to be the diseased action, viz. inflammation of the reticular or sub-peritoneal cellular tissue of the pelvis next the uterus. The substance of the uterus was not apparently implicated ; and all I could observe was that the anterior view of the uterus presented beneath its peritoneal covering a redness as if from increased vascularity. I had suggested that the rapid course of the disease to a fatal issue, and the low character of the symptoms, could scarcely be explained otherwise than by inflammation of the veins of the uterus ; but I examined these, and found no such morbid state—indeed I am convinced the disease was diffuse inflammation of the reticular texture, as I have stated, producing death with no greater effect than effusion of serum. Was it to be regarded as erysipelas ? this disease was rife both in the hospital and generally in Norwich at the time. I omitted to examine the os uteri—would a small laceration of it, as occasionally happens, particularly in first labours, induce traumatic erysipelas ? In such a case, bleeding is out of the question at the period when one is summoned to the patient, and the little I did in this way was still enough to hasten in some degree the fatal result.

Case 153.

Mr. B—— mentioned to me, that lately a patient after labour had peritoneal inflammation—he bled her twice—soon erysipelas on the buttocks appeared—internal inflammation was removed—she recovered. The conjunction or alternation of internal inflammation and visible erysipelas marks the connexion of the two, and should not be forgotten.

Fever and Rapid Pulse.—Case 154.

Mrs. ——, just under 21 years of age; second pregnancy. Mr. —— attended her, April, 1836, at full term, and after a difficult and very tedious labour, the face presenting, a living child of very large size was born. Nothing further occurred during or immediately after the labour, to excite apprehension or account for any unfavourable symptoms. Mr. —— remained some time after, I believe all night, and left the patient with a proper pulse, and all, as he thought, well; but next day he was summoned on account of pain in the back, also severe pain in the head—found much fever, not preceded by any marked rigor—pulse 140. The pulse got to 160, and I was called in consultation, on Friday, April 8th, near three days after delivery—pulse then 160—pain in the loins and right hip, from moving the lower limbs; but the patient lies on either side well; the body free from tenderness—no peritoneal inflammation indicated—lochial discharge going on. The external parts, which it was said, had been much swollen during labour, were found on examination to have subsided. An irritable patient, and the slightest exertion causes pain and throbbing in the head. I could make out no local inflammation; so quick a pulse would not be produced by active inflammation in an early stage—the cause of the evil was not apparent—I thought partial inflammation, as of the substance of the uterus or of the ovarium, might explain the matter; but could detect no such mischief—the bowels had acted well. I could see no propriety in bleeding, local or general. I advised a blister, if there was tenderness next morning, over the left ovarium, which seemed the region bearing pressure the least; but Mr. —— saw no indication for the blister next morning. By anodynes sleep was obtained; bland nourishment offered; the child put to the breast every four or six hours, as there is some

milk. So rapid a pulse excited great apprehension, though the cause was not apparent ; and one felt that such a symptom could not go on long. Next day, Saturday, profuse motions, some scybala, from a single small dose of castor oil—pulse 140—but in the evening 160 with intense pain and throbbing of the head, and threatening of mania.

Sunday, 10th. I found at this my second visit in consultation with Mr. ——, the pulse 150 to 160—the patient could sit up and turn on either side, complaining of soreness over the hips, pain in the loins, and down the lower limbs ; but the abdomen was yielding and bearing firm pressure in every part, over the uterus, ovaria, &c.—lochiæ still going on—milk disappearing. I now felt sure that no bleeding or blistering was, or had been since I first was called, admissible. I advised a little ammonia ; opiates at night ; bland nourishment of broth and jelly frequently, as much as could be taken. Turpentine might have been tried, as an empirical method of treatment ; but it is most nauseating, and was not suggested. I allowed a tea spoonful of wine diluted, but the patient, I was afterwards assured, could not take it, pain and throbbing of the head being produced—the hair was cut off to relieve the head. This patient told me that for four months before labour she took no malt liquor or wine, as she found it create palpitation and pain in the head.

Mr. —— reported of the next three days, that the pulse fluctuated never below 140 ; no wine could be taken ; the patient often fainted ; no hope entertained ; then a little rallying, but each night restless, in spite of opiate. In two days more there was rallying ; head-ache gone. Evacuation of fæces, some hard, and *such as Mr. —— thinks must have been weeks lodged.*

April 17. Pulse much subsided ; no pain, and apparently a promise of recovery.

May 6. This lady recovered ; but now complains of much pain in the back, about the pelvis, and in one limb.

Phlebitis.—Case 155.

Mr. —— called me to Mrs. ——, æt. 24 ; whose first labour occurred just above three weeks ago ; was difficult ; the forceps were used ; a healthy child was born, which is still living. Inflammation of the veins of the left lower limb occurred—chiefly

the veins about the leg. The present state of the patient, quite hopeless, will indicate what has been going on. There is an open abscess of the leg near the shin-bone, discharging matter largely ; the thigh greatly swelled ; the veins along the whole limb thickened ; enlarged glands at the fold of the left groin, and even a corded inflamed vein can be felt from this situation, mounting up the abdominal parietes. Poultice to the abscess, and hot fomentations to the thigh, groin, and lower part of the abdomen—pulse 120, small ; tongue and lips parched ; a hectic flush of a leaden hue on the cheek. A hopeless case, from the low fever induced by extensive phlebitis.

Phlegmasia Dolens.—Case 156.

———, æt. 20 ; first labour. After eight days I took my leave ; three days after she had chill and fever ; then pain in the groin ; there was subsequently pain in the calf of the leg ; these were followed by ædema of the foot and ankle ; in short a slight attack of phlegmasia dolens. I then learnt that even before delivery, and constantly since, there had been pain in the left groin. I was desirous to reduce the powers as little as possible, and applied only a few leeches, but without relief ; two or three blisters were afterwards applied to the upper part of the thigh with much benefit ; laxative doses ; restricted diet—the milk continued all this while. It was three weeks before I could support the limb with a bandage—then all did favourably. The pain in the calf of the leg seemed to be in the saphena vein.

Case 157.

In December, 1843, I saw, with Mr. ——, a patient æt. 23, three weeks or so after her confinement ; it was her third labour, the first having occurred two years ago ; and in a few days after this third successful delivery, she was seized with symptoms that passed for inflammation of the chest—treated by active antiphlogistic means ; and as soon as this disease yielded, affection of the head, regarded as of the same character, occurred, and was also actively treated ; cold applied to the head ; ice could not be got, which was regretted. The patient seemed going on better, when pain in the left groin and swelling of the left leg supervened, shewing *white swelling* from phlebitis. Leeching to

the groin, purging, warm fomentations most effectually, were the means tried; then the right groin became tender and the right leg swelled—leeches were again applied to this groin. Such was the state when I was called; both lower limbs greatly ædematous, the left enormously; great tenderness in the right groin; great emaciation, pallor, exhaustion, rapid small pulse; intolerance of light; the greatest depression of spirits; cold still applied to the head. I thought depleting treatment of every kind had been carried too far; and suggested a continuance of the warm fomentations so effectually applied to the lower limbs; the avoidance of purging; a blister over the groin if required (it was not required); saline and soothing medicine; removal of all cold applications from the head.

The patient in two or three days could bear the light; was much improved in spirits; the bowels acted spontaneously; the lower limbs, more enormously swelled than I had ever seen them in any patient, gradually subsided; after a while, tonics were admissible; and in three weeks from my being called in, the patient was convalescent. She had no opiates. One remarkable circumstance should be specially noticed—as soon as the ædema of the lower limbs began to diminish, a watery loss passed from the vagina, and increased till two or three pints, as the nurse asserted, were passed on the napkins and bed in 24 hours; and we both were strongly impressed with the belief that the serous fluid from the lower limbs passed into the uterus by the open orifices of the uterine vessels; thus giving a ready exit to what was superabundant, and relieving the ædema.

Remarks.

The importance of the diseases comprised under this head is strikingly represented by their fatality, and no other argument is needed to demonstrate very forcibly the necessity for their most careful and anxious consideration. Undoubtedly it follows that, if we neglect any opportunity of learning their nature and treatment, we run the risk of being, if not positively, yet negatively, instrumental to the death of a party, whose life might have

been of the most interesting importance, and whose death, unexpected and without previous illness, may have entailed the greatest amount of sorrow and distress.—A healthy woman, the mother perhaps of a numerous family, passes quickly and safely through another childbirth; she is thankful for her deliverance, and her attendants are delighted with their little charge; the medical attendant has, perhaps with too much haste and too little consideration, taken his leave. Ere long, he receives an urgent summons; the family are in alarm; and, on seeing his patient he finds her pallid, panting, restless, gasping, exclaiming; with spectral illusions, cold extremities, and without a pulse; and he witnesses with horror the death of a patient whom he had shortly before considered in safety, and whose life he might *possibly* have been the means of preserving, had he remained in the house, and understood how to restrain the hæmorrhage which has so suddenly removed a beloved mother from the society of her disconsolate husband and children. This is not an over-drawn picture, as the experience of many will testify; and no efforts can be too great to enable us to prevent or remedy *flooding after delivery.*

In the preceding 15 cases of this accident, 3 mothers died, and 12 recovered, yet several of them "so as by fire." The danger occurs from the uterus not being sufficiently contracted after delivery; and is often indicated by severe pain and rapid expulsion of clots or fluid blood. The pains are often complained of as being more distressing than those for expelling the child, and the subsequent pallid and distressed condition of the patient is very dreadful to witness. At other times the hæmorrhage may take place insidiously and without pain, either externally or into the cavity of the uterus; and then the first intimation of the danger may be a sudden yawning and

restlessness, with great pallor and exhaustion. Here, in spite of our fears, we must act boldly. The great object is to cause contraction of the uterus; and the most effectual means will be the exhibition of ergot of rye internally; the sudden application of cold to the region of the uterus and external parts of generation; pressure on, or friction over, the uterus *with the hand,* nothing else answers so well as the hand; grasping the uterus with the hand when contracted sufficiently to admit of this; and *after contraction,* giving a full dose of laudanum, with or without some tincture of ergot—the laudanum I look upon as a most important part of the treatment, and I never omit to use it after contraction has taken place—it appears to quiet the cerebral system, to restore the pulse, to refresh the body and counteract the general effects of loss of blood, as well as to remove all circumstances which might tend to interfere with the permanency of the uterine contraction. Unless the powers have been too much enfeebled by severe loss to bear the disturbance, putting the child to the breast is another important point to ensure contraction—indeed if this be done always as soon as possible after labour, hæmorrhage will rarely follow. When by these means the hæmorrhage has been stopped, and the uterus is small enough to be grasped by the hand of the accoucheur, it will be better for him to continue his hold for half an hour or so; after which it may be safe to apply a proper abdominal bandage instead—and although cold applications are in the first instance most important, *comforting,* and effectual, some of the preceding cases point out the danger of their being continued too long; when the hæmorrhage has been stayed for some time, and the uterus is well contracted, especially if the powers of the patient are much exhausted, cold ought to be no longer persisted in, but,

rather gentle and general warmth of the body encouraged.

Another means of obtaining contraction of the uterus, recommended by Authors on Midwifery, is the introduction of the hand into the cavity of the uterus; its object may be said to be three-fold; viz. to excite contraction by the presence of a foreign body in the uterus; to restrain hæmorrhage by the application of the hand over the bleeding vessels; and to remove clots. I cannot say that the introduction of the hand may not excite a uterus to contract sometimes when other means fail, but it is a painful operation, and surely to be avoided if possible, on the plea of the pain and disturbance it occasions to a patient, who may be already almost ceasing to exist. I feel confident that the application of the hand externally will *generally* be as successful; and this is always available, whatever may be the condition of the patient. With respect to the second object, I have no faith in it whatever, and believe it not at all to be depended upon; and as to the third, I can only say that I have been able to empty a uterus completely filled with clots, so as to occupy almost as much space as before delivery, and give rise to the suspicion of there being another child, by manipulations practised externally full 24 hours after delivery; I have, nevertheless, been present at a few cases in which the introduction of the hand was required, not simply to remove clots, but *to overcome some irregularity in the contraction of the uterus* keeping up hæmorrhage; and therefore, should other means fail, it is a perfectly justifiable proceeding. An enema of cold water is sometimes effectual in exciting contraction of the uterus, and I know of no objection to its being tried.

The other diseases comprised under this head are—

Syncope, Hysteritis, Peritonitis, Puerperal Fever, Phrenitis, Phlebitis, Diffuse Inflammation of the cellular membrane in the Pelvis, and Phlegmasia Dolens. Of Syncope 5 cases are reported, of which one died and 4 recovered, and their histories point out how much the safety of a woman in child-bed may depend upon the state of her mind; mental distress and despondency being sometimes apparently a sufficient cause for even fatal syncope. From cases such as these we may gather instruction as to one of our duties as accoucheurs, which is probably too often overlooked; namely, to administer comfort and consolation to the mind, as well as relief from suffering to the body.

Eighteen cases are included under the next four heads, and 16 were fatal. I have adopted the separate heads of Hysteritis, Peritonitis, and Puerperal Fever, because there appear to be symptoms peculiar to each, although they possess some characters in common; the difference between those of the two former being chiefly in degree; and those of the latter being more allied to typhus than to inflammation of serous membranes, and exhibiting after death a peculiar morbid anatomy in consonance with the diagnostic signs of low fever and depression which are present during life.

In the treatment of puerperal peritonitis or metritis in an acute active form, there can be no question as to the propriety of bleeding, general or local, followed by calomel and opium, and counter-irritation; many such cases are saved by these means, the symptoms are evident, the indications plain. But it is in the form of phlebitis that puerperal disease assumes its direst characters; that form which I have designated in particular puerperal fever; here the mischief is insidious in its commencement, the symptoms are indefinite, and the progress of the disease

is obscure. The fatality of this awful disease bears so large a proportion to the number of those attacked with it, that we must conclude either that the usual mode of treatment is inappropriate, or else that the disease is of so intractable a nature, as to be beyond the reach of remedies. The difficulties to be encountered in the treatment ought, however, to nerve us for the contest, and make us especially mindful to anticipate an attack by judicious precautionary measures. Prevention is better than cure, and it has often been strongly impressed on my mind, that cases of puerperal fever might have been prevented by soothing local applications, and the early internal administration of opiates; I have also thought that after-pains, if allowed to continue long without opiates, and treated, *as a matter of precaution*, with calomel, may lead to the supervention of uterine disease.—Indeed, I firmly believe that opium given early, and in doses proportioned to the urgency of the pain, is the best remedy for all abdominal pain occurring, without fever, soon after labour, whether it be considered after-pain, or suspected to be the commencement of an inflammatory attack.

There is great reason to believe that uterine phlebitis is often caused by the contact of fœtid discharges in utero with the uterine venous sinuses; for if these be not properly closed, either on account of imperfect contraction of the uterus or want of coagulating power in the blood (and these might both depend upon one and the same cause), the depraved fluid contents of the uterus may find a ready admission into the torrent of the circulation, and give rise to the phenomena of puerperal fever. Other causes may exist, such as a peculiar zymotic influence, the actual contact of morbid matter or effluvia from the hand of a surgeon recently dressing an erysipel-

atous sore, or opening a dead body, &c.; but whatever the original cause, offensive lochial discharge is always an accompaniment of the disease, and capable of adding fresh *materies morbi* so long as it remains in the uterus.—In addition, therefore, to the use of opium for the relief of pain, it is a good precautionary measure, to ensure full contraction of the uterus; and this may often be done effectually by administering a small dose of ergot with laudanum soon after labour, in addition to the usual abdominal bandaging; a practice I invariably adopt, unless the uterus contracts very powerfully at the time, and seems to require no additional inducement to keep so. But in those cases where, on account of imperfect contraction after labour, ergot is most wanted, there is frequently also a flabby muscular system generally, with weak health and poverty of blood; and since uterine contraction would not effectually prevent the admission of morbid matter through the sinuses into the circulation, unless the blood in those sinuses became coagulated so as to close them, it will be necessary to improve the general state of system by nourishment and astringent tonics, in order to impart to the blood a sufficient degree of contractile power to ensure coagulation in vessels through which it should cease to circulate. Should, however, these precautions have been either neglected or found ineffectual, and there is reason to believe the commencement of this frightful disease has taken place, what are we to do to prevent its progress and save the patient? Are we immediately to "throw in" calomel, with a view to affect the system as quickly as possible? It is a practice sanctioned by high authorities, and I believe extensively employed, but the results in the aggregate are by no means of a character to stamp it as a desirable means of attempting to effect a cure. Of the cases reported by

Drs. Hardy and Mac Clintock in their valuable work on Midwifery, and treated with calomel, how large a proportion proved fatal! and when we find so many terminating fatally with uncontrollable diarrhœa, it makes us hesitate to employ a medicine which, if freely used, is itself capable of producing the diarrhœa we should so gladly prevent, because, when it occurs in this particular disease, it seems almost sure to deprive the patient of all power to rally. If, furthermore, to prevent the absorption of unhealthy discharges, and to communicate to the blood an increased power of coagulation, be correct indications of treatment, surely mercury, which is said to increase absorption, and to lessen the coagulating power of the blood, cannot be a proper medicine to administer in doses sufficient to produce these effects.

Indeed I am so impressed with the belief that the free exhibition of mercury may render all our other efforts at restoration abortive, that I am unwilling to give it except early in the disease; and then only for the purpose of clearing the bowels of any disordered secretions they may chance to contain. Oil of turpentine has been very much recommended by a few writers, especially by Dr. Brenan, of Dublin, in 1814, Dr. Douglas, in 1822, and Dr. James Copland; the latter of whom thus remarks upon it in his *Dictionary of Practical Medicine:*—" This medicine (turpentine) was first employed for this disease by Dr. Brenan, of Dublin, and I can assert that it is the most efficacious remedy that can be employed in this form of puerperal fever. I state this from a lengthened and diversified experience of this substance in disease; and yet in England, I know not of any other physician than myself who has given it a satisfactory trial in puerperal fever, even up to the present day. I can assert that it is, according to the mode of its exhibition,

antiphlogistic in acute inflammations, and more efficacious in arresting the progress and consequences of asthenic or diffusive inflammations, than any other substance; whilst it possesses the property of accommodating, by its tonic and astringent operation, the vascular and capillary system to the state and amount of its contents, of lowering the frequency of the pulse, and of restraining effusion from serous and mucous surfaces."—Again, he says—" Having myself since 1815 prescribed this substance in numerous diseases, malignant, febrile, and inflammatory, and employed it in puerperal diseases, I have been induced to make enquiries respecting its use by other physicians; and yet, notwithstanding the notoriety of the practice, and its undoubted success if duly and appropriately prescribed, I have not heard of its having been employed by any other physician in this metropolis besides myself. This is somewhat singular, when the general fatality of the disease, and the highly favourable reports of the practice which have been made by Dr. Brenan, Dr. Douglas, and myself, are considered. What are the obstetric practitioners, who appropriate the treatment of puerperal diseases, about?"

Dr. Douglas states (*Dublin Hospital Reports,* vol. 3, p. 157), that in the epidemical and contagious puerperal fever, ʒiij. of the turpentine should be given, with an equal quantity of syrup, and ʒvj. of water, three or four hours after the first dose of calomel; and that after an hour this should be followed by an ounce of castor oil, or some other purgative; or the turpentine and castor oil may be given together; and he restricts the internal use of turpentine to twice only. " The external application," he adds, " without either its internal use, or the aid of blood-letting, I have frequently experienced to be entirely efficacious in curing puerperal attacks; and al-

though I have hitherto omitted to speak of turpentine for the cure of the other varieties of this disease, yet I should not feel as if I were doing justice to the community if I did not decidedly state, that I consider it, when judiciously administered, more generally suitable, and more effectually remedial, than any other medicine yet proposed. I can safely aver, I have seen women recover, apparently by its influence, from an almost hopeless condition, certainly after every hope of recovery under ordinary treatment had been relinquished." *

This strong recommendation from practitioners of considerable ability and experience, should undoubtedly influence others in the treatment of a disease which so frequently baffles all ordinary attempts at cure; and I have made the extract for the purpose of directing attention afresh to a remedy, which however valuable, is by no means generally employed.

There is often considerable difficulty in determining the existence of puerperal phlebitis in its early stage, but I believe even at that time, there is always something amiss either in the quantity or quality of the lochial discharge; we shall almost always be able to detect an unhealthy fœtor, and whenever this exists, we have reason to fear either that it is a consequence of mischief already begun, or that it will shortly produce it. I consider it important, therefore, under these circumstances, to pay the greatest possible attention to cleanliness, and to wash out the uterus, in order to free it from fœtid matter, which, if allowed to remain, may again and again be absorbed, continually adding fresh fuel to the disease, and rendering of none effect the best efforts we may otherwise make to retard its progress.

* Copland's Medical Dictionary. Art. Puerperal Fevers.

In accordance with this opinion, I quote a paragraph from a Treatise on the Diseases of Pregnant and Lying-in Women, by Charles White, of Manchester, dated 1791; and whoever will take the trouble to peruse the book, will find many useful suggestions and sound practical remarks. In the chapter on the "Cure of Puerperal Fever," he says, "I must not omit to mention the good effects I have experienced from emollient and antiseptic injections into the uterus, by means of a large ivory syringe, or an elastic vegetable bottle. In those cases where the lochia have become acrid and putrid, and by being absorbed into the circulation, have served as a constant *fomes* to the disease, I have by this means known the fever much assuaged, and in many cases wholly extinguished; for though the quantity of the lochia is not to be much regarded, the quality of this discharge is a matter of infinite importance." P. 223.

There is also an interesting case of Fever and Rapid Pulse, shewing how important it is not to frame our diagnosis upon any one symptom, however threatening; and another of diffuse inflammation, exemplifying the destructive nature of erysipelas, and the danger that may arise in that disease from contagion. It is clear that it amounts to a duty for a surgeon who is in attendance on a case of erysipelas, to avoid, *if possible*, at the same time officiating in a case of Midwifery.

The two cases of Phlegmasia Dolens recovered, and indicate the propriety of the treatment by blisters, warm fomentations, and gentle saline aperients, in preference to more active depletory measures—a fact I have been able to verify in several instances occurring under my own immediate observation.

CHAPTER XI.

DISEASES AND INJURIES OF INFANTS.

Sore from the use of the Vectis.

Case 158.

A child less than a month old is brought to me, June 11th, 1821, with a sore two or three inches long on the right side of the neck, just beneath the angle of the lower jaw and extending under the jaw. This was produced by the application of the vectis at the time of labour; the part which appeared only slightly scratched, afterwards sloughing. The sore is deep and extends under the lower jaw ; the child not able to take the breast in consequence of it, and its health bad. I can only direct the means of improving its health, and apply ung. calam. to the sore. It was a first child ; natural presentation ; labour tedious ; mother bled for fear of a fit ; her countenance swelling till she could not see out of her eyes ; but the duration of labour, with very strong pains, was not 24 hours ; and the necessity for applying the vectis, by which the child's life seems in danger of being sacrificed, was not urgent and possibly not justified.

Eruption and Inflamed Breast.

Case 159.

Mrs. D——'s infant, two or three days after its birth, had an abundant pustular eruption all over the body, not unlike that produced by antimonial ointment. After this, when a fortnight old, it had inflammation of the right breast, which proceeded to

suppuration—it burst and discharged a large quantity of pus, and, by poulticing, the wound healed soundly in a few days.—A milky fluid had discharged from the breasts of the infant before this, and stopped when the inflammation took place.

Congenital Tumor.

Case 160.

Mrs. M—— was delivered on the 14th of April, 1820, with a female child, having an enormous tumor, as big as my fist, on the buttock and left side of the anus. The tumor pressed the anus to one side, was tense, but yielded to pressure, giving no sense of fluctuation, but diminishing by pressure, and enlarging and becoming tense when the child screamed.—June 18th. The tumor has increased much ; small vessels are visible upon it ; but the skin may still be pinched up as distinct from it ; the rectum is compressed, and the motions are obstructed, so that within a few days, although small motions have passed, the abdomen is become immensely distended. This child lived till the beginning of July ; the tumor grew immensely, but did not burst ; and the day before death its circumference was 13 inches. In its growth it included the anus, which opened on the side of the tumor, an inch from its basis. After death, the tumor measured half an inch less in its circumference ; was pale-coloured, and without any vessels observable on the surface. I opened the abdomen ; found the bladder distended three inches above the pubes, and holding nearly half a pint of urine ; the rectum and lower part of the colon were also immensely distended, and contained several ounces of fæces, consisting of dark greenish substance mixed, but not perfectly incorporated, with a thick mucus, not unlike white of egg ; the distension of these organs had been produced by the tumor, which occupied the pelvis, but did not project into the cavity of the abdomen. No viscus was in any way diseased.

Dropsy and Contracted Ileum.

Case 161.

Mrs. A——, æt. 20 ; first pregnancy. March 22nd, had suffered from pains 60 hours, so severe and frequent as to pre-

vent her getting any sleep. A midwife was with her. I found the os uteri dilated to the size of a crown piece ; the pains were strong ; I could not feel the head, and from the size and shape of the part, believed it to be the breech presenting. She was delivered in five or six hours, and it proved that I had formed a right opinion. The child was small, but with an abdomen enormously distended ; it lived about 36 hours ; I opened it ; found above half a pint of clear very bright yellow fluid in the cavity of the peritoneum. The stomach, and a great portion of the small intestines continued from the stomach, were distended with air—towards its lower portion, the ileum was swelled out and distended for three inches with air and meconium ; it then suddenly contracted to the valve of the colon ; and this contracted portion was occupied by a firm pale mucus, as thick as the inspissated cerumen in the ear—the whole of the colon, a length of about 10 inches, was empty and contracted—a little meconium in the rectum. This child had passed nothing *per anum* during or after birth. I do believe that the obstruction at the lowest part of the ileum was insurmountable, as I could not push forward the meconium in the distended portion of the ileum with any force short of rupturing its coats. Might not this be the cause of the peritoneal dropsy ? and how far was the dropsy a cause of the malposition of the fœtus ? May not the deformity of the fœtus become a cause of an erroneous position of it *in utero*, as much as accidental violence, premature delivery, or deformed pelvis of the mother ? The meconium in the ileum was of the same dark appearance as that commonly found in the great intestine ; tingeing water yellow when mixed with it. Has meconium been before observed in the ileum ? and does not this shew that the dark and yellow meconium comes from the liver, a light coloured mucus only being added to it by the mucous surface of the intestines ?

There are many malformations and deformities affecting the Infant, which may create difficulty and delay in parturition, such as hydrocephalus, tumors, &c. There are other diseases, also congenital, which destroy the Infant soon after birth, by causing obstruction to the per-

formance of certain functions necessary to its new state of existence; and, what is still more distressing, the Infant is sometimes exposed to serious injuries, perhaps fatal ones, by an incautious use of instruments. The preceding cases are introduced as illustrations of some of these difficulties; but I forbear entering into any lengthened remarks for want of more ample materials to illustrate what might be usefully written concerning them. —Ed.

FINIS.

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